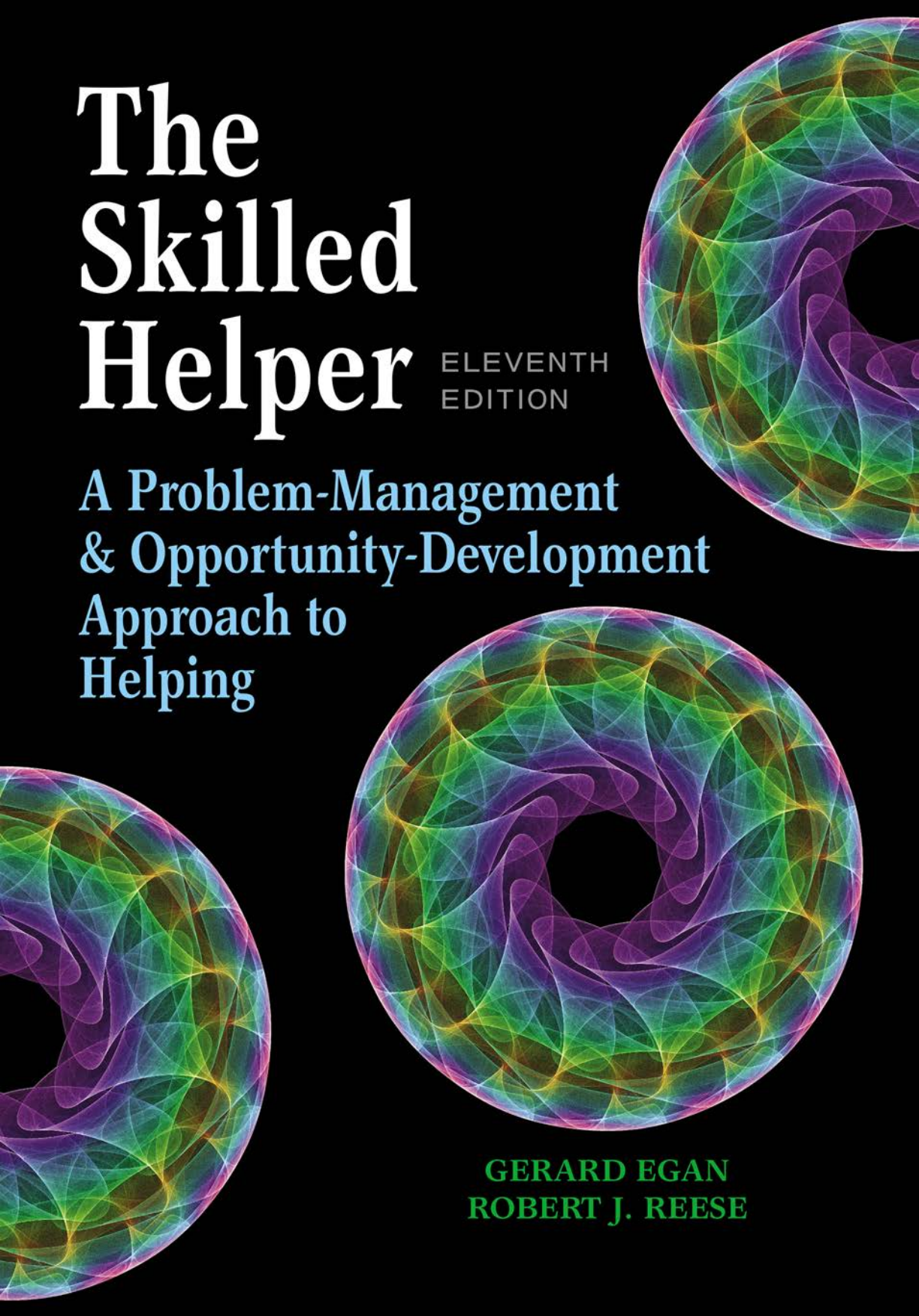


# The Skilled Helper

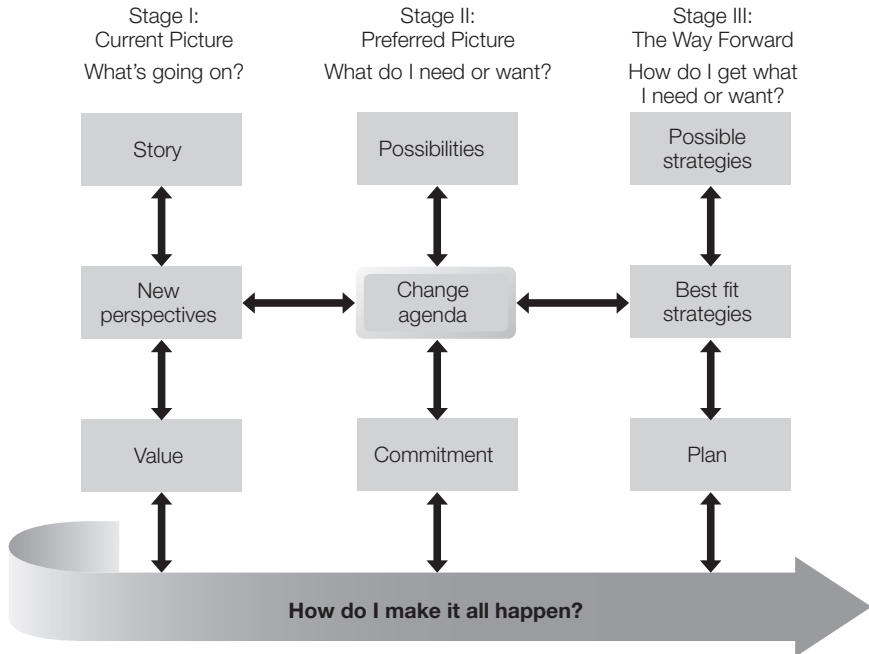
ELEVENTH  
EDITION

A Problem-Management  
& Opportunity-Development  
Approach to  
Helping

GERARD EGAN  
ROBERT J. REESE



## The Skilled Helper Model



### The Helping Dialogue:

#### Essential Communication Skills

- Tuning in
- Active listening
- Responding with empathy
- Checking understanding
- Probing
- Summarizing
- Challenging
- Negotiating



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ELEVENTH EDITION

# The Skilled Helper

A Problem-Management  
and Opportunity-Development  
Approach to Helping

Gerard Egan

*Professor Emeritus*

*Loyola University of Chicago*

Robert J. Reese

*University of Kentucky*



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and Opportunity-  
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Helping, Eleventh Edition**

**Gerard Egan and  
Robert J. Reese**

Product Director:  
Marta Lee-Perriard

Product Manager: Julie Martinez

Content Developer: Alexander  
Hancock

Digital Content Specialist:  
Jennifer Chinn

Digital Project Manager:  
Bonnie Yee

Manufacturing Planner:  
Karen Hunt

Intellectual Property

Analyst: Deanna Ettinger

Project Manager: Nick Barrow

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## PREFACE AND GUIDE TO THE 11TH EDITION

**W**hen I finished the 10th edition of *The Skilled Helper*, I said to myself, “Ten is enough. I’ve had it.” Obviously I was mistaken. So here is the 11th edition. All the useful themes developed over the past forty years—the primacy of client focus, the importance of life-enhancing client outcomes, the collaborative client-helper alliance, a problem-management and opportunity-development approach, the essential communication skills needed for effective client-helper dialogue, an emphasis on the values that drive the helping process, the importance of diversity—stay intact although once more they have been reorganized, simplified, and newly illustrated. This Preface reviews the changes and additions that have been made in the 11th edition. It also reviews some of the most important themes that make up the substance of *The Skilled Helper* and how they have been updated.

### A New Author

One of the most important updates is Jeff Reese, now co-author of both this book and the *Exercises in Helping Skills* workbook that accompanies it. He hails from the University of Kentucky and brings a strong research background to the enterprise. Here is a short bio:

Robert J. (Jeff) Reese, Ph.D., is Professor and Chair of the Department of Educational, School, and Counseling Psychology at the University of Kentucky. He teaches in the American Psychological Association accredited counseling psychology doctoral program and is directly involved with counselor training at the master's and doctoral levels. He has won numerous teaching and mentoring awards for his work with students, including the University of Kentucky Alumni Great Teacher Award and the Kentucky Psychological Foundation Outstanding Graduate Mentor Award. His research is focused in the areas of psychotherapy process/outcome, psychotherapy training and supervision, and the use of telehealth technologies to increase the availability of mental health services for underserved populations. Dr. Reese has several publications in top counseling and psychotherapy professional journals, and currently serves on the editorial boards of *Psychotherapy* and *The Counseling Psychologist*. Dr. Reese is also a licensed psychologist.

Jeff and I are both interested in how training programs in counseling and therapy can be improved.

## General Updating

As in other editions every word in the book has been scrutinized, citations have been updated, and many sections have been rewritten for the sake of clarity or to introduce new ideas.

## The Power of Basics™

I have come to realize that the popularity of *The Skilled Helper* lies in “the power of basics,” a phrase that I have trademarked, not for monetary reasons, but to keep it uncorrupted. The basics in this edition remain the same, but we have found better ways of designing, developing, and delivering them, for instance by using fresh, more contemporary examples to illustrate them. Basics are powerful but often ignored, even in the training of helpers. The basics here are called the “key ingredients of successful therapy.” *The Skilled Helper* has always emphasized the basics of effective therapy and has ignored the fads and “the next big thing” in the helping industry. This edition names, simplifies, clarifies, and organizes these basics more effectively.

## Examples

Speaking of examples, a reviewer once said that *The Skilled Helper* was worth getting for the examples alone. While this is an overstatement, you will find many new examples in this edition. Some include the context of the problem situation or unused opportunity. In isolation, examples can seem sterile. Context brings them to life. We continue to include ideas and examples from outside the helping professions, including ideas from business and organizational behavior. The source of an idea is not important; its therapeutic usefulness is.

## Science

The social sciences study human behavior in all its forms. They differ from the “hard” sciences in one very important way—the kind of probability involved. Human behavior can be studied rigorously, but it is more elusive than the realities that are the focus of the hard sciences. Helpers need a sense of this elusiveness. Practice-based evidence is as important as evidence-based practice. This edition depends heavily on practice-based evidence, which is expressed in many new or updated examples.

## Art

Is helping, in terms of therapy and counseling, science or art? The most realistic answer is “yes.” Given the unpredictability of human behavior, helping is essentially an art. While the value of the common factors outlined here has been confirmed through research, organizing them at the service of the client is an art. In that sense, this edition is unapologetically filled with art.

## Professional versus Academic Approach

From the beginning, *The Skilled Helper* was designed for professional rather than academic programs. At best it should be used to train would-be helpers in both the art and science of helping. To oversimplify, academic programs focus on understanding, while professional programs focus on doing. My fear is that many training programs do not make sure that graduates in helping-focused programs are fully competent in all the basics outlined here. The helping industry needs top-notch theorists, top-notch helpers who fully understand human behavior, and top-notch researchers. But our clients need top-notch doers who can help clients do whatever needs to be done to manage their problems and develop their unused opportunities.

## The Universality of the Standard Problem-Management Model

In this edition we claim that all approaches to therapy, directly or indirectly, use some form of what we call the Standard Problem-Management and Opportunity-Development Model of managing change (see Chapter 2) to help clients manage problem situations. This model or process is not about schools of psychology, interesting theories, or the latest fads. It is about people with problem situations and unused opportunities. This process—broadly speaking, a context-focused cognitive-behavioral-emotive approach to therapy—is presented as a valid treatment approach in itself. It is also a tool of psychotherapy integration. We use it to organize the common factors at the service of our clients.

## Learning Objectives in the Form of Doing Objectives

A major change in the 11th edition is the introduction of Learning Objectives (LO) in each chapter. However, in the professions, the fullness of learning takes place only when the practitioner translates learning into doing, that is, into some form of behavior that helps clients manage their lives more effectively. In *The Skilled Helper*, then, learning objectives are really “doing” objectives (DO). Effective helpers know that grappling with problems in living is hard work and do not hesitate to caringly invite those seeking solutions to buckle down and engage in that work. But not work for the sake of work. In the end helping is about work that produces outcomes that favorably impact the lives of help seekers.

## Design Thinking and Action Learning

Though currently popular, design thinking is no more (and no less) a version of the problem-management and opportunity-development framework. I have some fear that it is becoming a fad, but at its best it provides a new language and new life to the problem-management framework. There are many different ways

of delivering the four stages of the problem-management framework. Design thinking emphasizes creativity.

Action learning is also a form of the basic problem-management and opportunity-development process. It has a rich history based on solid research. It is a learning-by-doing process. It also shows how to turn learning into doing. It helps clients develop core strengths for problem solving such as the ability to formulate and ask meaningful questions. “Meaningful” here means questions related to goal-focused and goal-achieving action. Clients learn that there are no single, right answers to most problems in living. They learn that answers come from experiments and other forms of action. Like design thinking, action learning focuses on innovation that comes from reviewing and experimenting with a number of possibilities.

## Helpers and Clients as Entrepreneurs

Helpers at their best are entrepreneurs in that they constantly are looking for better ways to deliver therapy and ways to make the helping industry more inventive. The essential characteristics of an entrepreneur and ways in which entrepreneurship can be used to help clients are outlined. Helping clients themselves to become more entrepreneurial in managing problems and exploiting opportunities are explored. This approach could turn into a fad, but the basics of entrepreneurship and the basics of helping fit very well together.

## Decision-Making

This edition makes it even clearer that effective decision-making (and its shadow side) lies at the heart of problem management and opportunity development and, therefore, at the heart of therapy. Most of the examples used involve some form of decision-making. Effective helpers understand both the bright and the dark sides of decision-making and become guides as troubled people muse about, make, glide toward, flirt with, or fall into decisions—or attempt to avoid them. They also help clients explore the possible unintended consequences of the decisions they are making. Because decision-making has a deep shadow side, the more therapists understand its inner workings the better.

## Flexibility

The essential uncertainties associated with human behavior play an important role in therapy and require helping approaches that are both rigorous and flexible. The importance of flexibility is too easily ignored. The 11th edition further helps readers (i.e., would-be therapists) to use models and methods flexibly. Unfortunately, this caution is too often ignored.

## Multiculturalism and Personal Culture

This edition further promotes the concept of “personal culture,” that is, the way that each individual lives out the beliefs, values, and norms of the larger social culture. Diversity at the individual client level takes precedence over any particular form of diversity such as multicultural diversity. The personal culture of each individual client includes his or her incorporation and expression of ethnic and cultural themes together with all the other forms of diversity in his or her makeup. If social culture is “the ways *we* do things, then personal culture refers to “the way *I* do things” as a member of any given culture. An  $N = 1$  research approach to the evaluation of progress in therapy provides the kind of rigor that fits clinical situations while respecting the personal culture of each client.

## The Importance of Challenge

The tendency of the helping industry to avoid the term “challenge” receives greater attention in the 11th edition. There is increased focus on *invitations* to clients to engage in self-challenge and the concept of helper self-challenge is further developed. Therapy itself is presented as a form of positive challenge. Effective helpers know that grappling with problems in living is hard work and do not hesitate to caringly invite those seeking solutions to buckle down and engage in that work. But this is not work for the sake of work. In the end helping is about work that produces outcomes that favorably impact the lives of help seekers.

## Reorganization and Simplification of Chapters

All of the above has led to extensive reorganization and restructuring of the book and the rewriting of most chapters at the service of simplicity and coherence. For this purpose, the number of chapters has been reduced from 14 to 11. The book has three parts. Part I deals with the “key ingredients” approach, the role of the problem-solving and opportunity-development process, the catalytic role of the therapist, the importance of the helping relationship, and the values that drive the entire helping process. Part II focuses exclusively on the communication skills therapists need to engage in a collaborative outcome-focused dialogue with clients. Part III deals in detail with the problem-management and opportunity-development approach. The contents of each part are spelled out in the Guide that begins on page xiii.



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Walter, Weijun, Weilian, William, Yoshi, Yugi*

*You've all played a part. Thank you.*

# A CHAPTER-BY-CHAPTER GUIDE TO THE 11TH EDITION

Here is a chapter-by-chapter guide to help both instructors and students to get a sense of the whole before diving into the detail of each chapter. The book has three major parts:

**Part I: Introduction** has three chapters.

*Chapter 1* reinforces the fundamental client focus of therapy and the three goals that contribute to this focus. *Client focus* is the key ingredient of the helping process. Throughout the book the importance of keeping the client “in the driver’s seat” is emphasized. Then, under the title of “the key ingredients of successful therapy” it names and describes our version of the clinical application of the “common factors” research carried out over the past decade.

*Chapter 2* is an overview of the problem-management and opportunity-management process that serves as the therapeutic model. Even though this model is presented in detail in Part III of the book, an overview is presented here because it serves to organize everything else.

*Chapter 3* addresses three of the key ingredients of successful therapy: (1) the role and competence of the therapist together with the therapist’s skill at orchestrating the key ingredients and tailoring them to each client’s needs; (2) the *collaborative therapeutic relationship* between client and helper; and (3) the *values* that should permeate and drive the helping process together with the importance of the *beliefs-values-norms-ethics-morality* dimensions of life as manifested in the social and personal culture of the client.

**Part II: Therapeutic Communication Skills** has four chapters. These chapters focus on the communication skills needed by therapists to engage and interact successfully with clients. This group of skills constitutes one of the key ingredients of successful therapy. Therapists can use these skills to help clients improve their communication aptitude and engage meaningfully in the therapeutic dialogue.

*Chapter 4* highlights and illustrates the nature of the *therapeutic dialogue* between client and helper together with three basic skills of *therapeutic presence*: tuning in to clients, remaining engaged, and active listening.

*Chapter 5* presents empathy, not as a value as in Chapter 3, but as a communication that brings this value to life. Basic and advanced empathy are central communication skills.

*Chapter 6* outlines how therapists can use *probing and summarizing* to help clients engage more fully in the helping process.

*Chapter 7* considers the role and rationale of *challenge* and *client self-challenge* in therapy. It details ways helpers can invite clients to engage in self-challenge with regards to thinking, behaving, and expressing emotions without telling them how they must think or behave.

**Part III: The Problem-Management and Opportunity-Development Process** has four chapters devoted to a detailed presentation of the problem-management and opportunity-development process of helping outlined in Chapter 2. The problem-management process is a key ingredient of successful therapy in two ways. First, all forms of therapy incorporate, directly or indirectly, many, if not all, of the dimensions of the Standard Problem Management Process, that is, they discuss directly or infer problem exploration, goal setting, finding ways of achieving problem-managing goals, and the ups and downs of implementing goal-accomplishing plans. Second, this process seems to be a psychological universal. People around the world readily recognize its broad strokes, even though, like most of us, they do not use it readily or effectively.

*Chapter 8* (in previous editions titled *Implementation: Help Clients Make It All Happen*) addresses the importance of an action mentality in therapy. While it may seem odd to consider implementation at this point, it is never too soon to highlight the importance of both helper and client action. The value called “a bias toward action” was considered in Chapter 3. Chapter 8 brings this value to life. It reaffirms the notion that problem-managing action on the part of clients should, with prudence, start as early as feasible in the helping process. Obstacles to implementation and ways of overcoming them are reviewed. Finally, the power of both resilience and posttraumatic growth are celebrated.

*Chapter 9* deals with the three tasks (A, B, and C) of *Stage I*. Remember that a task is nothing more than something a therapist can do to help a client move forward in some part or phase of the problem-management process.

Task I-A outlines how therapists, using the communication skills discussed in Part II can help clients explore their concerns and presents guidelines for helping them do so. This chapter also shows how the very telling of stories by clients can suggest to them things that they can do to begin moving in the right direction without, of course, engaging in premature or inadvisable action.

*Chapter 9* also describes and illustrates the other two tasks of *Stage I*. Task I-B discusses ways therapists can help clients develop new, more accurate, and more useful perspectives on their problem situations. This task also describes ways that counselors can invite clients to challenge the ways they think, behave, and express emotions.

Task I-C outlines ways therapists can help clients to focus on the right issues—right, that is, for the clients. This means issues that will make a life-enhancing difference in their lives. This task underscores the continual search for client-benefitting value throughout the helping process.

Chapter 9 makes two things clear. First, these three tasks related to helping clients tell their stories are not linear. Rather they intermingle and interact. Second, these three tasks are useful *throughout* the entire helping process, that is, in all three stages. First of all, clients do not necessarily tell the whole story all at once. They often add things to the basic story throughout the helping process.

Second, new perspectives and self-challenge are welcomed in every stage. Third, it is important not only to work on the right issue, but also to set the *right goals*, and to come up with the *right set of strategies and the right plan* for achieving these goals.

*Chapter 10* describes the three tasks (A, B, and C) of Stage II (Help Clients Set Problem-Managing Goals and the Plans to Accomplish These Goals). A goal is defined as a desired problem-managing outcome. Task II-A poses and suggests ways of answering this key question, “What would things look like if this problem situation was managed or this opportunity developed?” This task is about discovering possibilities for a better future. It highlights the importance of creative thinking.

Task II-B deals with helping clients choose problem-managing goals. Problem management is filled with decision-making. Therapists help clients make life-enhancing decisions. Task II-C is about helping clients explore the quality of their commitment to both the goals they choose and the entire problem-management process.

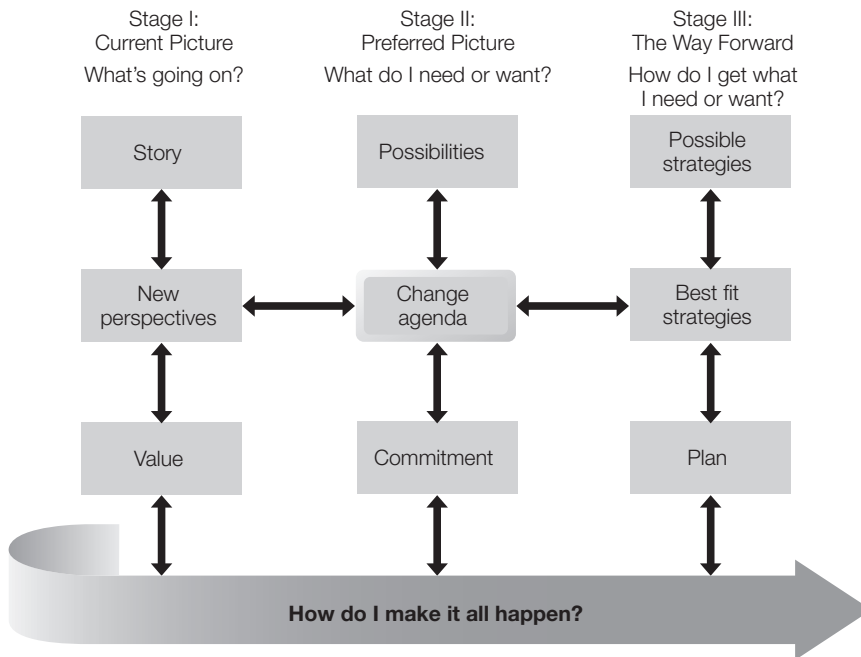
*Chapter 11* describes Stage III (The Way Forward: Help Clients Make Plans to Accomplish Goals) and its three tasks. Task III-A outlines ways of helping clients discover strategies for achieving goals. Task III-B focuses on helping clients choose a strategy or a set of strategies that best fit the client’s style and resources. Task III-C shows ways of helping clients organize these strategies into a workable plan. This chapter points out how important it is for therapists to turn the “mechanics” of problem management as outlined in these chapters into a fully human experience.

## Becoming a Skilled Helper

If you come to a good understanding of all the models, methods, and skills described and illustrated in this book, would you be “a skilled helper”? Not yet, because knowledge and competence are not the same thing. You need to be trained in these models, methods, and skills. The Introduction to *Exercises in Helping Skills: A Manual to Accompany THE SKILLED HELPER* (Egan & Reese, 2018) outlines a rigorous training methodology that I have used over the years to train aspiring helpers in a number of different cultures. The manual, which is part of the training program, gives you an opportunity to get a feeling for and, eventually, basic competence in the models, methods, and skills outlined in this book. The full training methodology, which includes practice and supervision, would speed you on your way, but then would you be a skilled helper? Maybe.

A skilled helper is more than a technician, even a very competent technician. Helping others is more than a job, more than a career. The helping professions call for more than just knowledge and competence. There is a *vocational* dimension to it. I have been going to the same doctor for over thirty years. Medicine is his vocation. We have great conversations. He does not do medical research, but he shares the latest findings in medical research when he believes they will benefit me. Spending time with him is not just a visit; it is an event. We need people like him in the helping professions. You are lucky. You can start down that path right away.

## The Skilled Helper Model



### The Helping Dialogue: Essential Communication Skills

- Tuning in
- Active listening
- Responding with empathy
- Checking understanding
- Probing
- Summarizing
- Challenging
- Negotiating

# The Power of Basics

**A**lthough the centerpiece of this book is a problem-management and opportunity-development framework that encompasses all the ingredients of successful helping (Part III) and the communication and relationship-building skills needed to engage in the client-helper dialogue (Part II), it is important to start with a consideration of the power of basics, both in helping and in life in general (Part I).

In Part I, Chapter 1 briefly reviews the power of basics in general terms before outlining the basics of helping, called here the “key ingredients” of successful therapy. Chapter 2 describes the problem-management and opportunity-development process that is, itself, one of the basics. Moreover, this process provides an organizing framework for all the other basics. Chapter 3 focuses on the helping relationship and the values that drive it. All three chapters highlight the client-centered (rather than helper-centered) and the outcome-focused (rather than helping-approach-focused) nature of helping espoused in this book.





# The Power of Basics: Explore the Ingredients of Successful Helping

### LEARNING OBJECTIVES

#### 1.1 Review the Roles of Both Formal and Informal Helpers

#### 1.2 Appreciate the Power of Basics

#### 1.3 Become Competent in the Key Ingredients of Successful Helping

1. Focus Primarily on the Client and the Contextual Factors of the Client's Life
2. Define Success in Terms of Outcomes with Life-Enhancing Impact for the Client
3. Describe What an Effective Therapist Looks Like
4. Develop a Working Alliance with the Client
5. Acquire the Communication Skills at the Heart of the Therapeutic Dialogue
6. Integrate the Basic Principles Related to Cognition, Behavior, and Emotions into the Helping Process
7. Use Feedback to Improve the Effectiveness of the Helping Sessions and Clients' Change Efforts
8. Come to Grips with the Role of Beliefs, Values, Norms, and Moral Principles in the Helping Process
9. Help Clients Redo Poor Decisions and Make and Execute Life-Enhancing Decisions
10. Adopt a Treatment Model Aligned with the Universal Problem-Management Process

#### 1.4 Move from Smart to Wise by Managing the Shadow Side of Helping

#### 1.5 Embrace Uncertainty

## Review the Roles of Both Formal and Informal Helpers **LO 1.1**

Throughout history people the world over have held a deeply embedded conviction that, under the proper conditions, some of us are capable of helping others come to grips with problems in living. This conviction, of course, plays itself out differently in different cultures, but it is still a cross-cultural phenomenon. Today this conviction is often institutionalized in a variety of formal helping professions. In Western cultures, counselors, psychiatrists, psychologists, social workers, and ministers of religion among others are counted among those whose formal role is to help people manage the distressing problems of life.

A second set of professionals, although they are not helpers in the formal sense, also help people in times of crisis and distress. Included here are organizational consultants, dentists, doctors, lawyers, nurses, probation officers, teachers, managers, supervisors, police officers, and practitioners in other service industries. Although these people are specialists in their own professions, there is still some expectation that they will help those they serve manage, at least indirectly, a variety of problem situations. For instance, teachers teach English, history, and science to students who are growing physically, intellectually, socially, and emotionally and struggling with developmental tasks and crises. Teachers are, therefore, in a position to help their students, in direct and indirect ways, explore, understand, and deal with the problems of growing up. Managers and supervisors in work environments help workers cope with problems related to job performance, career development, interpersonal relationships in the workplace, and a variety of personal problems that affect their ability to do their jobs. This book is addressed directly to the first set of professionals and indirectly to the second.

To these professional helpers can be added any and all who try to help others come to grips with problems in living: relatives, friends, acquaintances, and even strangers (on buses and planes). This is informal helping. In fact, only a small fraction of the help provided on any given day comes from helping professionals. Informal helpers—bartenders and hairdressers are often mentioned—abound in the social settings of life. Friends help one another through troubled times. Parents need to manage their own marital problems while helping their children grow and develop. Indeed, most people grappling with problems in living seek help, if they seek it at all, from informal sources (Swindle, Heller, Pescosolido, & Kikuzawa, 2000). In the end, of course, all of us must learn how to help ourselves cope with the problems and crises of life. Sometimes we do this on our own, but at other times we seek help from mostly informal sources. This book is about the basic ingredients of successful helping. It is designed to assist you in becoming a better helper no matter which category you fall into.

Here is a broad definition of counseling agreed to by 29 major counseling organizations after years of debate: “Counseling is a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals” (see Kaplan, Tarvydas, & Gladding, 2014). It highlights three very important factors: the centrality of clients’ needs and wants; next the fact that clients themselves, empowered by the helping process, must act to achieve a better life; and finally that success

is defined in terms of life-enhancing client outcomes—not just outcomes, but outcomes with impact.

## Appreciate the Power of Basics LO 1.2

The basic working knowledge and skills that people need to engage in any human endeavor effectively are, of course, important. But because they are basic, they are often overlooked or taken for granted. For instance, the basic working knowledge and skills people need to live effective social lives—interpersonal communication and relationship-building skills—fall into this category. Many people think they have these basic skills when, in fact, they do not. In most societies these skills are not named or described in a direct way. Nor are they taught. People are expected to “know what these skills are” and “pick them up” along the way. Some people do; many do not. Many companies expect their employees to be “good communicators,” but they do not say what they mean by that term and often go on to hire people who are not good communicators, do little to help them develop these skills, and end up living with the consequences. Many see the basics as boring. In truth they are powerful.

I believe that The Skilled Helper has been successful over the years precisely because it focuses, not on the “latest thing” or on any particular model, method, or approach to counseling and therapy but on the basic working knowledge and skills that helpers need to do a competent job. The students who entered the graduate programs I have overseen quickly learned that they needed to show competence in the working knowledge and skills outlined and illustrated in this book if they wanted the degree. Occasionally this even meant begrudgingly retaking a course to acquire the skills and demonstrate competence. “I know I haven’t developed the skills, but I now know how important they are, so can’t I just move on?” one student pleaded. “No” was the answer. Program directors owe it to the clients whom these students will ultimately serve to make sure that their helpers have competence in the basics. In my view even the helping professions too often overlook the power of the basics.

## Become Competent in the Key Ingredients of Successful Helping LO 1.3

Let us call the basics in counseling and therapy “the key ingredients of successful helping.” This book is not just another model, approach, or school of helping (some say there are hundreds) nor is it an overview of the most common approaches to therapy (there are many books that review these). Rather it is a practical overview of the basic working knowledge and skills that any helper needs no matter which school or approach he or she chooses to use.

Many helpers and writers have used the term “**common factors**” to designate the essential ingredients of successful therapy. Why use the term “common factors”? To answer that question, consider the following situation. There are ten therapists. Each of these helpers espouses one of the following approaches to therapy: behavior therapy, rational-emotive-behavior therapy, narrative therapy, emotion-focused therapy, reality therapy, person-centered therapy, brief dynamic

therapy, cognitive behavioral therapy, existential-humanistic therapy, and relational-cultural therapy. I have chosen these ten approaches because a book on each has been published recently by the American Psychological Association as part of an Introduction to Psychotherapy Series. Each of these ten therapists has ten clients. Each set of ten clients has similar problem situations with an analogous range of degrees of severity. That is, the ten groups are comparable. The common trait that these therapists share is that all ten are equally successful in that all hundred clients are successful in managing, within reason, the problem situations of their lives. All the therapeutic encounters lead to life-enhancing outcomes for the clients. If this is the case, then it cannot be said that the principal vehicle of success was the treatment approach because there were ten different approaches. So it makes sense to ask: What do these successful helpers have in common? What root factors (basics) make for their success? Their ability to use their preferred model or approach to serve the needs of their clients is one of the basics, but just one. What are the other factors? Over the past ten years, a great deal of research has been done to identify them (Duncan, 2014; Duncan, Miller, Wampold, & Hubble, 2010; Norcross, 2011; Wampold, 2010a, 2010b). Later in this chapter we will consider the role of treatment models. While research shows that the specific treatment model contributes relatively little to success in therapy, this does not mean that it does not serve an important purpose.

Different researchers have come up with different “packages” of common factors. There is also a great deal of both agreement and disagreement as to which package is “right.” See the Special Section: Common Factors in *Psychotherapy* (December, 2014, 467–524) for a bewildering array of opinions (most claiming to be “evidence-based”). Laska, Gurman, and Wampold (pp. 467–481) courageously wrote the main article (pp. 467–481) and, at the end (519–524), tried to make sense of it all, taking their own shots at the “empirically supported treatment” movement. This is how psychology works. Perhaps to avoid some of the unending controversy that plagues the helping profession, I prefer the term “key ingredients of successful helping.” My list is more or less in agreement with what researchers have discovered and is based on over forty years of practice and the training of hundreds of helpers (“practice-based evidence”). Therefore not everyone would agree that the list outlined here is the “right” list, developed in the “right” order, and supported by the “right” evidence. There is no such list. What Hubble, Duncan, Miller, and Wampold (2010) say of the common factors is true of the set of ingredients outlined here. That is, they are “not invariant, proportionally fixed, or neatly additive. Far from it, they are interdependent, fluid, and dynamic” (p. 34). Moreover, each ingredient has, like many things in psychology, its associated uncertainties. And so while it is important to name, describe, and illustrate each ingredient, the ingredients themselves are interactive and dynamic in actual helping encounters. In practice they overlap. The purpose of this book is to bring them alive through descriptions, examples, and discussions.

In this chapter we list the common factors, or ingredients, that we see as essential for competent helping. We also set out the reasoning behind my inclusions and let you and the helping profession itself be our judge. Discord in the helping industry should not surprise us. The social sciences deal with human behavior,

which is often messy, disordered, and difficult to predict. Human behavior has a type of probability different from the probability associated with the so-called “hard sciences—physics, chemistry, biology, and cosmology (the STEM grouping: science, technology, engineering, and mathematics). Engineering a rocket to send a technology package to land on a fast-moving comet is one thing. Helping an addict “engineer” his or her behavior is another. And so debate, sometimes acrimonious, about psychological realities is part and parcel of the helping professions. There will always be a degree of uncertainty about the findings of the social sciences. Here is a list stated in terms of things you have to do:

1. Focus Primarily on the Client and the Contextual Factors of the Client's Life
2. Define Success in Terms of Outcomes with Life-Enhancing Impact for the Client
3. Describe What an Effective Therapist Looks Like
4. Develop a Working Alliance with the Client
5. Acquire and Use the Communication Skills at the Heart of the Therapeutic Dialogue
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The pages of this book are filled with examples of life-enhancing client outcomes. So we turn our attention to the ingredients that both individually and collectively lead to or produce outcomes with impact. Each ingredient together with some of the uncertainties associated with it are described here and then explored and illustrated throughout the book.

### **1. Focus primarily on the Client and the Contextual Factors of the Client's Life**

Let us call the person seeking or needing help a client rather than patient to avoid, at least for the time, the dispute about the use of the medical model in helping (Wampold, 2001, 2010). The client in his or her search for life-enhancing outcomes is the first and most important “ingredient” in the therapeutic process (Bohart & Tallman, 2010). However, much of therapy research has focused on the model or method of treatment. What clients themselves bring to the party, however substantial, has been shortchanged. This is odd because research shows that clients together with what they bring to therapy are responsible for most of the success or failure in the helping endeavor (Dunkin, 2010; Orlinsky, Rønnestad, & Willutzki, 2004).

Let us become more concrete. We will use cases to help bring the concepts discussed in this book to life. Here is the case of Karl and his helper Laura.

Karl was a veteran of two wars. His first stint was in Iraq, his second in Afghanistan. His tour in Afghanistan ended abruptly after his squad was ambushed near the Pakistani border. Two of his best friends were killed. Karl escaped with relatively minor injuries. Minor physical injuries, that is. When he first returned to base he seemed to be alright but about a month later the dam broke. Not only did the full range of posttraumatic stress disorder (PTSD) symptoms flood through him off and on—nightmares, flashbacks, bouts of anxiety and depression, irritability, insomnia, social avoidance, trouble concentrating, feeling emotionally numb—but he also began ruminating and agonizing over his pre-military life, especially poor decisions he had made. For instance, after high school he decided to join the army instead of going to college. During his first year in the army he broke up with his girlfriend, believing that “the military and deeper relationships did not mix.” He let himself “drift away from God.” It is not that he led an immoral life, rather his “beliefs became twisted.” This caused feelings of guilt. Early on he was told that all of this was probably only temporary. But that was not the case. He had his “good days,” but various PTSD symptoms kept popping up “for no reason at all.” He returned to the United States. But on a sick-leave furlough in his hometown, he found relationships with family and friends “difficult.” Army doctors decided that he was not fit to continue to serve in the army. An honorable discharge was arranged. Many of Karl’s symptoms persisted. Some grew worse. For instance, he began thinking that he could have done something to prevent the deaths of his friends and this increased the burden of guilt. While he did not entertain suicidal thoughts, he did wonder about servicemen who had taken their own lives. How bad could things get? He knew that he could never take his own life, but he began to understand why some people do. What he saw ahead of him was a life of misery. He resisted all but intermittent help—“I’m no psycho”—and, reluctantly and intermittently, took some medication for both anxiety and depression. Finally, at the urging of a VA Medical Center physician, he agreed to seek more substantial psychological help—“I’ll try anything.” Well, almost anything. Karl did not want to get involved with a VA therapist because he wanted to distance himself from the military—“I want to leave all that behind.” He believed that working in a VA setting would, for him, be part of the problem rather than part of the solution. So Karl and Laura, who works in a mental health clinic associated with a Christian hospital near where Karl lives, become client and helper. Because the hospital is near an army camp, Laura has seen a number of soldiers, but none “just like” Karl.

What do clients like Karl bring to the helping encounter? They arrive with their version of humanity in all its simplicity and all its complexity. Here are some of the things clients bring with them, in no particular order:

- The problem situations, issues, concerns, in various degrees of severity, for which they are seeking help.
- Successful or failed attempts to manage problem situations and/or exploit unused opportunities.
- The past to the degree that it is affecting them positively or negatively in the present.
- Their general life expectations and aspirations, however realistic or distorted, and associated disappointments.

- Their skills, strengths, and resources.
- Their general emotional state.
- Their hopes, fears, and expectations regarding therapy.
- Their degree of openness to and readiness for change.
- Their willingness to work at change.
- Whatever reluctance or resistance they feel.
- Their ability to engage in a collaborative relationship.
- Their sense of right and wrong, their personal ethics, their approach to morality.
- Their cultural beliefs, values, and norms of behavior, especially particular version of their dominant culture and its impact on their behavior.
- The entire range of their relationships together with all the associated ups and downs, especially the relationships related to their current problem situations.
- Their level of interpersonal communication skills.
- Their blind spots.
- External factors that stand in the way of progress.
- External factors that support constructive change.

This is just a partial list, but all of them are relevant to Karl's situation. Since people are complex, it is important for helpers to identify factors that are key for each client. Or even better, it is important for clients, often with the help of a therapist, to discover the key factors that have an impact on their problem situations. In the end the quality of the client's participation in the therapeutic endeavor is the major determinant of outcome. So Karl needs a therapist who can help him give his best to the therapeutic process. Clients are or should be in the driver's seat with respect to managing problem situations in everyday life. It is essential that therapists help them get into the driver's seat and stay there throughout the helping process. Therefore, for the reasons outlined by Duncan and Sparks (2010), if there are any heroes (an over-used and misused word) in the therapeutic endeavor, they are the clients themselves rather than the therapists. Karl is responsible for life-enhancing change. His helper is a catalyst for that change.

There are client-associated uncertainties. Consider Karl. He, like the rest of us, is a complex human being and complexity breeds uncertainty. There are many issues that he could explore. Which factors from his past are having a negative impact in the present? Does he need to confront his problems head on or is it better to find ways to transcend them? What outcomes does he want beyond relief from both depressive moods and anxiety? To what degree are PTSD symptoms just that, symptoms, with other underlying issues as the main concern? But neither Karl nor Laura can afford to be overwhelmed by the natural complexity of human beings. With Laura's help Karl must determine what the key issues are and what he is going to do about them.

***Determine why clients seek help*** To determine what helping is about, it is useful to consider (1) why people seek—or are sent to get—help in the first place and (2) what the principal goals of the helping process are. Many people become clients because, either in their own eyes or in the eyes of others, they are involved



in problem situations that they are not handling well. Others seek help because they feel they are not living as fully as they might. Many come because of a mixture of both. Therefore clients with problem situations and unused opportunities constitute the starting point and the primary focus of the helping process.

*Problem Situations.* Clients come for help because they have crises, troubles, doubts, difficulties, frustrations, or concerns. Although the generic term “problems” is often used, these are not problems in a mathematical sense because they usually cause emotional turmoil and often have no clear-cut solutions. It is probably better to say that clients come not with problems but with problem situations—that is, with complex and messy problems in living that they are not handling well. These problem situations are often poorly defined. Or, if they are well defined, clients still do not know how to handle them. Or clients feel that they do not have the resources needed to cope with them adequately. If they have tried solutions, they have not worked.

All of us face problems in living. Problem situations arise as we interact with ourselves, with others, and with the social settings, organizations, and institutions of life. Clients—whether they are hounded by self-doubt; tortured by unreasonable fears; grappling with the stress that accompanies serious illness; addicted to alcohol or drugs; involved in failing marriages; fired from jobs because of personal behavior, office politics, or disruptions in the economy; confused or abused in their efforts to adapt to a new culture; returning from some battlefield with the psychological ravages associated with war; suffering from a catastrophic loss; jailed because of child abuse; struggling with a midlife crisis; lonely and out of community with no family or friends; battered by their spouses; or victimized by racism—all face problem situations that move them to seek help. In some cases, these problem situations move others—such as teachers, supervisors, and the courts—to refer people who are not managing their problems very well to helpers or even mandate that they seek help.

Even people with devastating problem situations can, with help, handle these situations more effectively. Consider the following example.

Martha S., age 58, suffered three devastating losses within six months. One of her four sons, who lived in a different city, died suddenly of a stroke. He was only 32-years-old. Shortly after his death, she lost her job in a downsizing move stemming from the merger of her employer with another company. Then, her husband, who had been ill for about two years, died of cancer. Though she was not destitute, her financial condition could not be called comfortable, at least not by middle class North American standards. Two of her surviving three sons were married with families of their own. One son lived in a distant suburb. The other son lived in a different city. The unmarried son was a sales representative for an international company who traveled abroad extensively.

After her husband's death, she became agitated, confused, angry, and depressed. She also felt guilty. First, because she believed that she should have done “more” for her husband. Second, because she also felt strangely responsible for her son's early death. Finally, she was deathly afraid of becoming a burden to her children. At first, retreating into herself, she refused help from anyone. But eventually she responded to the gentle persistence of her church minister. She began attending a support group at the church. A psychologist who worked at a local university provided some direction for the group. Helped by her interactions within the group, she slowly began to accept help from her sons. She began to realize that she was not the only one who was

experiencing a sense of loss. Rather she was part of a “grieving family,” the members of which needed to help one another cope with the turmoil they were experiencing. She began relating with some of the members of the group outside the group sessions. This helped fill the social void she experienced when her company laid her off. She had an occasional informal chat with the psychologist who provided services for the group. Eventually, through contacts within the group she got another job. Gradually her depression eased and, despite some persistent anxieties, she found a sense of peace.

Note that help came from many quarters. Her newfound solidarity with her family, the church support group, the active concern of the minister, the informal chats with the psychologist, and upbeat interactions with her new friends helped Martha enormously. Furthermore, because she had always been a resourceful person, the help she received enabled her to tap into her own unused strengths.

It is important to note that none of this “solved” the losses she had experienced. Indeed, the goal of helping is not to “solve” problems but to help the troubled person manage them more effectively or even to transcend them by taking advantage of new possibilities in life. Problems have an upside. They are opportunities for learning.

*Missed Opportunities and Unused Potential.* Some clients come for help not because they are dogged by problems like those listed above but because they are not as effective as they would like to be. Therefore clients’ missed opportunities and unused potential constitute a second starting point for helping. Most clients, like the rest of us, have resources they are not using or opportunities they are not developing. People who feel locked in dead-end jobs or bland marriages, who are frustrated because they lack challenging life goals, who feel guilty because they are failing to live up to their own values and ideals, who want to do something more constructive with their lives, or who are disappointed with their uneventful interpersonal lives—such clients come to helpers not to manage their problems better but to live more fully.

It is not a question of what is going wrong but of what could be better. It has often been suggested that most of us use only a small fraction of our potential. Most of us are capable of dealing much more creatively with ourselves, with our relationships with others, with our work life, and, generally, with the ways in which we involve ourselves with the social settings of our lives. Consider the following case.

After 10 years as a helper in several mental health centers, Carol was experiencing burnout. In the opening interview with a counselor, she berated herself for not being dedicated enough. Asked when she felt best about herself, she said that it was on those relatively infrequent occasions when she was asked to help provide help for other mental health centers that were experiencing problems, having growing pains, or reorganizing. The counselor helped her explore her potential as a consultant to human-service organizations and make a career adjustment. She enrolled in an organization development program at a local university. In this program she learned not only a great deal about how organizations work (or fail to work) but also how to adapt her skills to organizational settings. Carol stayed in the helping field, but with a new focus and a new set of skills.

In this case, the counselor helped the client manage her problems (burnout, guilt) by helping her identify, explore, and develop an opportunity (a new career). The helper was a catalyst; Carol took the lead.

***Use positive psychology wisely to focus on unused opportunities*** Helping clients identify and develop unused potential and opportunities can be called a “**positive psychology**” goal. Seligman and Csikszentmihalyi (2000) called for a better balance of perspectives in the helping professions. In their minds, too much attention is focused on pathology and too little on what they call “positive psychology.” They propose, “Our message is to remind our field that psychology is not just the study of pathology, weakness, and damage; it is also the study of strength and virtue. Treatment is not just fixing what is broken; it is nurturing what is best” (p. 7). They and their fellow authors discuss such upbeat topics as: subjective well-being, happiness, hope, optimism, the capacity for love, forgiveness, civility, nurturance, altruism, an appreciation of beauty and art, responsibility, self-determination, courage, perseverance, moderation, future mindedness, originality, creativity, talent, a civic sense, spirituality, and wisdom. Traditionally, this has not been the ordinary language of the helping professions.

Seligman and Csikszentmihalyi’s challenge has stimulated a great deal of theory, research, debate, and practical programs for helping clients to identify and tap into unused resources and opportunities (Biswas-Diener & Dean, 2007; Carr, 2004; Diener & Biswas-Diener, 2008; Dykens, 2006; Ince, 2009; Peterson, 2006; Seligman, 2004; Seligman, Steen, Park, & Peterson, 2005; Siegel & Allison, 2009; Simonton & Baumeister, 2005; Snyder & Lopez, 2005, 2006). Helping is not just about “fixing,” but about enabling clients to design and redesign their lives. Ince (2009) in a Harvard Medical School Special Health Report refers to positive psychology as “the science of satisfaction” (p. 2). Obviously both fixing and redesigning have a place in helping and one often melds into the other. Effective counselors help clients choose the mix that is best for them. The “materials” of designing/redesigning are the often-overlooked resources within the client—strengths, values, beliefs, and pools of resilience that currently lie unnoticed. Sometimes it is better to help clients transcend problems than to work through them. Positive psychology suggests ways of doing just that. For instance, Olivia put a great deal of effort into developing a full life outside her workplace. She cultivated friendships, tutored disadvantaged kids in math, engaged in a reasonable but rigorous exercise regimen, and read extensively about current events in order to continuously enlarge what she calls her “sense of the world.” All of this made it much easier for her to put up with the petty politics that permeated her workplace. She would have put more energy into finding a better job, but the job market was very tight. When asked about life, she would say, “Life is good. I do what I can to make it that way.” Her positive-psychology approach helped her transcend the problems of her workplace.

You will find the positive psychology research and literature useful in striking a balance with your clients. But, because there is a human tendency to turn what is useful into a fad, a note of caution is appropriate. Positive psychology is not an “everything’s going to be all right” approach to life. Richard Lazarus (2000) put it well:

[It] might be worthwhile to note that the danger posed by accentuating the positive is that if a conditional and properly nuanced position is not adopted, positive psychology could remain at a Pollyanna level. Positive psychology could come to be

characterized by simplistic, inspirational, and quasi-religious thinking and the message reduced to “positive affect is good and negative affect is bad.” I hope that this ambitious and tantalizing effort truly advances what is known about human adaptation, as it should, and that it will not be just another fad that quickly comes and goes. (p. 670)

Ongoing research (McNulty & Fincham, 2012) challenges the often-inflated claims made in the name of positive psychology. And this is only right. However, at its best, helping by whatever name (counseling, therapy, psychotherapy) engenders clients’ hope for a better life. Clients with hope are more likely to achieve life-enhancing goals. We will discuss hope in more detail in Part III. Although this is not a book about positive psychology, the spirit of positive psychology permeates the approach to helping outlined and illustrated here.

## **2. Define Success in Terms of Outcomes with Life-Enhancing Impact for the Client**

Success in helping consists of life-enhancing outcomes for clients (Goldberg, et al., 2016). A great deal of the helping literature focuses on the models, methods, and skills of helping. Less of this literature focuses on outcomes. This is a pity. Duncan, Miller, and their associates (2010), and a growing number of researchers and practitioners are working to introduce a better balance in the helping professions. They talk about “client-directed and outcome-informed” (CDOI) helping. As indicated above, the primary focus of helping is the client with unmanaged problem situations and/or unused resources, strengths, and opportunities. But because helpers do not solve or manage clients’ problems, it is essential to help clients become agents of change in their own lives. And change means life-enhancing outcomes in terms of problems managed and opportunities identified and developed.

Chad felt devastated. While he was taking a shower, his friend Gus, who was waiting for him to go to a meeting, tapped into Chad’s computer. The screen came to life with a full-color pornographic scene. When Chad finished his shower, Gus began kidding him about what he had found. “Gee, she doesn’t look like Erin” (Chad’s wife). Chad kept his cool and dismissed Gus’s remarks. But inside he was not cool at all. He and Erin had been married for about five years. They wanted kids, but “not now.” The initial ardor of their marriage had cooled, but neither had done much to deepen their relationship. They both worked and career demands always took precedence. Chad felt deeply ashamed, not because of Gus, but because he had been revealed to himself. He felt cheap. He had let pornography “supplement” and even take the place of a deeper social and sexual relationship with Erin. In fact, he was addicted.

The incident with Gus shocked Chad into taking a down-to-earth look at his relationship with himself and with his wife—in itself a positive outcome. Moreover, he hated the idea of being an addict—to anything. In a couple of sessions with a counselor, he realized more fully how he had been taking his marriage for granted and came to the conclusion that both he and Erin needed to be in “this counseling thing” together. They both quickly realized that they had to stop drifting. They found ways of “reinventing” their marriage in all its dimensions, including its sexual dimensions. Chad, despite a lapse or two, stopped substituting pornography for the “real thing.” Erin began to think of how she would eventually have to balance career and motherhood. But a “better marriage” was key to this balancing act. They began doing more things together and liked it.

Walters and Spengler (2016) review helper discomfort with certain topics, especially pornography, and discuss possible errors helpers may make because of this discomfort. In the above case, Chad's counselor had a very negative view of pornography, but he kept his views to himself and helped Chad discover what he thought was best for himself.

As we have seen, clients come to helpers primarily because they want or need to manage specific problems situations more effectively and/or develop unused opportunities in order to live life more fully. This is the first goal of helping. But counseling, done right, can help them achieve two other goals. Let us take a brief look at all three. Read what follows and then return to Chad and Erin's case and see if you can find elements of all three goals.

**Goal One: Life-Enhancing Outcomes.** Help clients manage their problems in living more effectively and develop unused or underused resources and opportunities more fully at the service of life-enhancing outcomes.

Helpers are successful to the degree to which their clients—through client–helper interactions—see the need to manage specific problem situations and develop specific unused resources and opportunities more effectively. Notice that I stop short of saying that clients actually end up managing problems and developing opportunities better. Although counselors help clients achieve valued outcomes, they do not control those outcomes directly. In the end, clients can choose to live more effectively or not.

Helping is an “-ing” word: It includes a series of activities in which helpers and clients engage. These activities, however, have value only to the degree that they lead to valued outcomes in clients' lives. Ultimately, statements such as “We had a good session,” whether spoken by the helper or by the client, must translate into more effective living on the part of the client. If a helper and a client engage in a series of counseling sessions productively, something of value will emerge that makes the sessions worthwhile. Unreasonable fears will disappear or diminish to manageable levels, self-confidence will replace self-doubt, addictions will be conquered, an operation will be faced with a degree of equanimity, a better job will be found, a woman and a man will breathe new life into their marriage, a battered wife will find the courage to leave her husband, a man embittered by institutional racism will regain his self-respect and take his rightful place in the community.

Clients and people who interact with clients such as family, friends, peers, and co-workers can perceive the kind of results discussed in this book. Kazdin (2006), who works with families and children, emphasizes the importance of moving beyond change based on statistical significance and even clinically significant change-to-change that has palpable impact on clients' daily lives. Kazdin, in an article on the importance of the behavioral indications of positive change in clients' lives, cites an example of outcomes that make a difference in the everyday life of a child with “conduct disorder” and the lives of those who interact with him.

For example, one can see that the child no longer beats up a parent, teacher, or siblings; has stopped running away from home; does homework for the first time; no longer steals from neighbors; no longer brandishes a knife with younger siblings or peers; interacts appropriately with an infant sibling (e.g., talk, gentle play) rather

than physically abusing him or her; and becomes only mildly upset during a tantrum at home without any of the usual property destruction. (p. 47)

The need for “palpable” results is not new. Effective helpers have realized this throughout the history of helping. Over thirty years ago Driscoll (1984) saw this clearly in his work with Andrea N., a battered woman.

The mistreatment had caused her to feel that she was worthless even as she developed a secret superiority to those who mistreated her. These attitudes contributed, in turn, to her continuing passivity and had to be challenged if she was to become assertive about her own rights. Through the helping interactions, she developed a sense of worth and self-confidence. This was the first outcome of the helping process. As she gained confidence, she became more assertive; she realized that she had the right to take stands, and she chose to challenge those who took advantage of her. She stopped merely resenting them and did something about it. The second outcome was a pattern of assertiveness, however tentative in the beginning that took the place of a pattern of passivity. When her assertive stands were successful, her rights became established, her social relationships improved, and her confidence in herself increased, thus further altering the original self-defeating pattern. This was a third set of outcomes. As she saw herself becoming more and more an “agent” rather than a “patient” in her everyday life, she found it easier to put aside her resentment and the self-limiting satisfactions of the passive-victim role and to continue asserting herself. This constituted a fourth set of outcomes. The activities in which she engaged, either within the helping sessions or in her day-to-day life, were valuable because they led to these valued outcomes. (1984, p. 64)

Andrea needed much more than “good sessions” with a helper. She needed to focus on and work toward outcomes that made a difference in her life.

**Goal Two: Learning How to Help Oneself.** Help clients become better at helping themselves in their everyday lives.

Clients often are poor problem solvers. Or whatever problem-solving ability they have tends to disappear in times of crisis or personal challenge. What G. A. Miller, Galanter, and Pribram (1960) said many years ago is, unfortunately, probably just as true today.

In ordinary affairs we usually muddle about, doing what is habitual and customary, being slightly puzzled when it sometimes fails to give the intended outcome, but not stopping to worry much about the failures because there are too many other things still to do. Then circumstances conspire against us and we find ourselves failing where we must succeed—where we cannot withdraw from the field, or lower our self-imposed standards, or ask for help, or throw a tantrum. Then we may begin to suspect that we face a problem. . . . An ordinary person almost never approaches a problem systematically and exhaustively unless he or she has been specifically educated to do so. (pp. 171, 174).

Many people in our society are still not “educated to do so.” And if many clients are poor at managing problems in living, they are equally poor in identifying and developing opportunities and unused resources. We have yet to find ways of making sure our children develop what most consider to be essential “life skills” such as problem management, opportunity identification and development, sensible decision-making, and the skills of interpersonal relating.



It is no wonder, then, that clients—often poor problem solvers to begin with—often struggle when crises arise. If the second goal of the helping process is to be achieved—that is, if clients are to go away better able to manage their problems in living more effectively and develop opportunities on their own—then helpers need to impart the working knowledge and skills clients need to move forward. As Nelson-Jones (2005) puts it, “In the final analysis the purpose of using counseling skills is to enable clients to become more skilled in their own right. . . . Counselors are only skilled to the extent that they can be successful in skilling clients” (p. 14). That is, helping at its best provides clients with tools to become more effective self-helpers. Therefore, although this book is about a process that helpers can use to help clients, more fundamentally it is about a problem-management and opportunity-development process that clients can use to help themselves. This process can help clients become more effective problem situation managers and opportunity developers, better decision makers, and more responsible “agents of change” in their own lives.

**Goal Three: A Prevention Mentality.** Help clients develop an action-oriented prevention mentality in their lives.

Just as doctors want their patients to learn how to prevent illness through good nutrition and healthy activities, just as dentists want their patients to engage in effective prevention activities, so skilled helpers want to see their clients anticipate problem situations rather than merely manage them, however successfully, once they have arisen. In marriage and other relationships the economics of prevention are extraordinary. In health care every dollar spent in prevention saves, by some estimates, ten in cure. People who develop good nutrition and exercise habits not only avoid a host of physical complaints but also enjoy energy levels that can be poured into other life-enhancing activities. But prevention is fundamentally problematic. If we are good at it, bad things do not happen. If we get sick, we can see, touch, and sometimes literally taste, the cure. But the benefits of prevention are often invisible. The very materiality of cure makes it more attractive, or at least more noticeable, than prevention. While it is true that some people thoroughly enjoy a good workout and glory in making the USDA MyPlate guidelines to nutrition a centerpiece of their eating lives, many others do not. Prevention is invaluable, but we must help clients work at making it attractive for themselves.

Counseling at its best provides an opportunity for helping clients embark on the prevention path. Take the case of Ingrid and Carlos:

Four years into their marriage they found themselves sitting unhappily with a marriage counselor, pointing fingers at each other. With the help of the counselor they began, painfully, to come to grips with problems dealing with financial decisions, sexual relations, and child rearing (two children). The counselor pointed how, over the years, they both had experienced “pinches”—small annoyances—in their interactions. For instance, Ingrid noticed that Carlos was rather generous in buying small things for himself, but expressed mild resentment when she did the same. But she said nothing. On the other hand, Carlos thought that Ingrid at times was less spontaneous, less “into it,” in their sexual relations, but still resented it whenever she thought he was giving another woman a second glance. But he said nothing. The



problem was that both of them “saved up” the pinches until they erupted, or even exploded, into “crunches”—major blowups in their relationship. And the number of crunches had begun to grow (the original pinch-crunch model is from Sherwood and Glidewell, 1973, but an Internet search will reveal a number of variations of this very useful prevention-focused conflict-management model).

The counselor helped Ingrid and Carlos do three things. First, he helped them defuse and manage their most acute problem situation, which dealt with childcare. Second, he not only taught them the rudiments of the problem-management and opportunity-development approach to counseling he was using (the one that is described and illustrated in this book), but helped them use this process to manage some of the financial problems they faced. He pragmatically “walked them through” the model as a way of providing them with a set of skills they could use on their own in the future. They used the model to deal with financial problems. Third, from a prevention point of view, he helped them see that ignoring or “saving up” pinches almost inevitably led to crunches. In talking with them separately, he discovered that they both had a reasonably solid set of communication skills. But, strangely enough, they did not use these skills when talking with each other. He showed them how they could use their communication skills to defuse the pinches that creep into relationships. He made them aware that negotiating is not restricted to country-to-country relationships or to what Democrats and Republicans do as a last resort, if ever. Rather fair-minded negotiation is part of everyday communal living. The counselor introduced the clients to resources, which they then used.

### 3. Describe What an Effective Helper Looks Like

A great deal of research focuses on different kinds of client problems and different kinds of treatment for these problems. It is the stuff of abnormal psychology. But, strange to say, over the years relatively little research has been done on the key capabilities and characteristics of the therapist (Beutler et al., 2004). But we do know some key things. We know that the person of the therapist is more important than the method of treatment (Crits-Christoph et al., 1991; Duncan, Miller, Wampold, & Hubble, 2010; Wampold, 2001; Wampold & Brown, 2005). We also know that some therapists are better than others (Castonguay & Hill, 2017; Okiishi, Lambert, Nielsen, & Ogles, 2003). But what makes some better than others? Wampold (2011), in a review of what research does say about therapists, comes up with a list of characteristics, which I have adapted. An effective therapist:

- Has a solid set of interpersonal skills and through them expresses acceptance, warmth, and empathy. These are discussed and illustrated in Part II.
- Acts in such a way as to build trust with clients. “This person understands me. I believe this person can help me.”
- Does his or her part to develop a collaborative working alliance with clients and come to an agreement with them on the goals of helping.
- Understands the client’s condition and can provide a plausible explanation for the source of the client’s distress.
- Understands both the client and the client’s problem situation in every relevant context—cultural, social, economic, political, and so forth.

- Has a flexible helping approach or treatment plan and communicates this approach clearly to the client.
- Is believable, persuasive, and convincing without robbing the client of his or her autonomy or dignity.
- Collaborates with clients in monitoring their progress and their views of the helping process.
- Establishes a formal or informal feedback system.
- Makes adjustments to the therapeutic process based on an evolving understanding of the client's problem situation, formal or informal feedback, and signs of client reluctance or resistance.
- Helps clients, despite their difficulties, to develop a realistic sense of possibility, hope, and optimism.
- Does not avoid difficult issues related to the client's problems or to the client-helper relationship, but handles them tactfully.
- Understands self, and injects self into the therapeutic dialogue only to the degree that this helps and does not distract the client.
- Knows the best research related to the client: the client's personality, the client's problems, the social context, and possible treatments for the client.
- Is committed to professional self-improvement. Understands the best the helping industry has to offer and makes it available to the client.
- Has a solid grasp of the key ingredients of successful therapy and, through collaboration with the client, knows how to tailor and orchestrate them at the service of client outcomes.

There are a lot of items on this list and there is no one right way of mixing and matching them to the client's needs. A Special Section of seven highly academic articles on the assessment of helper competence fills most of the pages of an issue of *Professional Psychology: Research and Practice* (2007, 38, 441–537). In these articles the enormous ambition of setting up a professional “cradle to grave” assessment system covering all helping-related competencies, including “knowledge, skills, dispositions, self-perceptions, motives, and beliefs-attitudes” (Kaslow and associates, 2007, p. 443) is outlined. At times they present helping almost as an adjunct to the medical profession. But assessing the competence of a gall bladder surgeon is one thing; assessing the competence of a marriage counselor is quite a different thing. The 15 guiding principles for the assessment of competence are brutally thorough and highly academic. Lichtenberg and his associates (2007) outline some of the challenges to creating a picture of the competent helper and conclude that “achieving consensus within the [helping] profession and across its diversity of specialties, orientations, and models on the necessary competencies for professional practice is a critical first step” (p. 478). Professionally, it seems that we are still at the starting gate. Although there is some kind of broad consensus that helping in the main helps and that there is a set of “common factors” that contributes to successful helping, practitioners are divided as to just what competence is in helping relationships.

Because there is no “right” or “perfect” set of characteristics, let me take the role of client and answer that question for myself, that is, let me personalize the

list. What kind of therapist would I want? For this exercise I have chosen Laura, a counselor I know. You ask “Why Laura?” Here is my response.

I have chosen Laura because she understands and can deal competently with all the factors being outlined and illustrated here as key ingredients in successful helping. However, she works with me in adapting these ingredients to my needs rather than to her theories. She has no preset formula. She is smart and she is competent, but she shoves neither her intelligence nor her competence down my throat. She is a pro but wears her professionalism lightly. Her professional skills are there to serve me. For her, helping is not just a job. I do not know whether she sees it as a vocation, but I do know that she is totally there all the time. She respects me and is street smart. I feel secure with her; I’m in good hands. She has excellent communication skills, including the ability to help me communicate when my own communication skills fail me. The values that drive her behavior emerge in the way she conducts herself, but she takes pains to understand my values and to help me see how they drive my behavior. She neither cudgels nor coddles me. But she does invite me to explore the unintended consequences of both my past decisions and the ones I am about to make. I like her invitational stance, knowing that I want a catalyst, not an advice-giver. The problem-management framework outlined in this book floats seamlessly in the background. It’s the geography of helping. We collaborate. We are a team, a unit. She is not afraid of work and assumes that I am willing to work at managing my problems. She is not a heroic figure. Sometimes she makes mistakes, but she readily admits them and works with me in reversing them. Right from the beginning she points out how important it is to establish a good working relationship. She explains the value of feedback. At the end of each session we evaluate what we have accomplished. What went right? What went wrong? How can we do better? At the beginning of each session we review what kind of progress I have made in managing my problem situation or some aspect of it. For us, feedback is a two-way street. The work we are engaged in is about life-enhancing outcomes. If I seem lax, she invites me to review my commitment. This is not her demand but rather my need. We explore the incentives I have for creating a better life for myself. We talk about obstacles that stand in the way of a better life or obstacles that I put in the way. We are honest with each other.

This is the kind of therapist I would like. Others would rather have a different mix of ingredients. For instance, in one study (Murphy, Cramer, & Lillie, 1984), clients who were mainly from the lower socioeconomic class wanted advice, signs of real interest in their problems, encouragement and reassurance, understanding, and the instillation of hope from their helpers. But the principle remains: within reason, work with the client to tailor the ingredients of therapy to his or her needs and preferences. As we shall see throughout this book, this does not mean indulging the client.

If you are interested in becoming a therapist, you may want to read Barry Duncan’s article (2011) entitled “What do therapists want?” He first answers this question by saying, “It’s certainly not money or fame!” That is interesting in a society whose media screams at us everyday that life is about money and fame. He cites a study (Orlinsky & Rønnestad, 2005) that provides some answers that are both sobering and uplifting: “Therapists stay in the profession, not because of material rewards or the prospect of professional advancement, but because—above all—they value connecting deeply with clients and helping them improve.

On top of that the clinicians interviewed consistently reported a strong desire to continue learning about their profession . . ." (p. 40). They found satisfaction in deepening their sense of themselves, their clients, the profession, and the world. Therapists-to-be have much to mull over as they choose the helping professions.

Laura brings her own culture, personality, and approach to the helping process. She uses the cognitive-behavioral-social-emotional problem-management approach (outlined in this chapter and described in detail in Chapter 2) to organize her thinking about therapy and her interactions with her clients. She also uses this problem-management process as a kind of "browser" to explore other approaches and extract methods and skills that are useful for clients. She organizes them within the problem-management framework. So, like many therapists, she is eclectic in her approach but with an eclecticism that is organized, client-centered, and outcome-oriented. The richness of her understanding of the helping process is a positive factor. But this richness involves complexity and therefore uncertainty. The uncertainty comes from the fact that methods and skills must be adapted to the needs of each client. She needs to understand Karl before enlisting his help to adapt any particular PTSD treatment program to his needs. PTSD is not a disease but a package of interrelated dysfunctional elements or symptoms. Karl is Karl, not his symptoms. She is competent, but her competence is not related to some kind of professional ideology. Rather it is related to meeting the needs of clients. She also knows that competence is a moving target. She has to keep at it throughout her career (Chow, Miller, Seidel, Kane, & Thornton, 2015). All in all, if you become competent in the basics outlined in this book, you will be well on your way of becoming one of the "better" therapists described and discussed in the helping literature. But remember, there is no one right way.

#### 4. Develop a Working Alliance with the Client

According to the research, the second most important ingredient in helping (after client factors) is the quality of the relationship between client and helper (Muran & Barber, 2010; Norcross, 2011). Generally speaking, if client and helper are a collaborative team, the three goals or outcomes listed earlier in this chapter are more likely to be achieved. The therapist's intelligence and competencies come alive and produce results only to the degree that they are channeled into the establishment and development of a collaborative client-helper relationship. Furthermore, while the therapist can do a great deal to see that this happens, it will not happen unless clients do their part. So it is up to the therapist and the client in their dialogue to orchestrate the mix of ingredients that best leads to targeted life-enhancing outcomes.

The American Psychological Association Interdivisional Task Force on Evidence-Based Therapy Relationships chaired by John C. Norcross (Norcross, 2010, 2011a, 2011b; Norcross & Wampold, 2011) came up with a range of conceptual conclusions regarding the client-helper relationship. Instead of a list of findings, here is how these findings might influence Laura directly and Karl indirectly. Laura says to herself:

Karl and I should make building and focusing our relationship a top priority. Focus means making sure that our emerging relationship is contributing to the main work at hand, namely Karl's dealing with the problematic issues of his life. Our

relationship will contribute more to Karl's search for life-enhancing outcomes than any helping approach I take. I have to make sure that Karl understands the problem-management approach I will be taking. I have to do my best in helping him see its value and buy into it. I have to be open to adapting my approach to his needs and do so without compromising my professional standards. I don't own the approach. Karl and I own it together. I have to make sure that Karl, if he so chooses, has a say in everything. Any therapeutic approach or program will lose its power if the relationship is poor. I will suggest programs or parts of programs that have been demonstrated to work with clients to, say, alleviate anxiety and/or depression, but Karl and I must be co-owners and collaborative implementers of these programs. We both need to understand, at some level of consciousness, that the relationship pervades every aspect of the treatment. My skills come to life only through the relationship. Karl is not an anesthetized patient undergoing an appendectomy where skills and techniques are of paramount importance. I deliver my skills and techniques through the relationship. So I cannot take even a PTSD treatment program that has been demonstrated to be effective and apply it like a technician, even a skilled technician. So there are many things I need to do to make this relationship work, especially understanding Karl from his point of view, even when I think that he might profit from challenging his point of view. And there are things I must avoid such as hostile interchanges, critical comments, rejection, and blame. I must continually remind myself that no one formula fits every client. I have had some clients who felt short-changed when I failed to challenge them. Other clients have resented even tactful invitations on my part to self-challenge. Everything I do must help Karl become a partner.

The members of the Task Force also issued a caution. Given the complexity of and the moving parts in the helping process, their findings should be taken with a grain of salt: "Readers are encouraged to interpret these findings in the context of the acknowledged limitations of the Task Force's work." Cautions like that could be issued for all the findings of the social sciences. So Laura needs to remain flexible and take her cues from Karl. Given its importance, the helping relationship is addressed in greater detail in Chapter 3.

All relationships have the potential for complexity and uncertainty. The helping relationship is a particular kind of relationship. It has to be established relatively quickly and must, from the beginning, be focused on client-enhancing outcomes. That said, it is always a work in progress. Collaboration is a two-way street. Karl and Laura keep adjusting to each other. Laura has entered into any number of these relationships, while, in a sense, everything is new to Karl. This makes things somewhat uncertain. Adding to the uncertainty is the fact that right now he is a person who is "out of community." To what degree is he capable of establishing the kind of collaborative relationship needed in therapy? Therefore helping Karl get into the driver's seat and helping him stay there could possibly breed more uncertainty.

## **5. Acquire the Communication Skills Needed to Engage in the Therapeutic Dialogue**

Helping has been called a "talking cure." Indeed, communication is at the heart of any relationship. Poor communication, however described, is often the bane of relationships. So helpers need a range of communication skills to become effective collaborators with their clients. In training helpers, I emphasize professional

competence in basic communication skills. Not all training programs do. These skills are so important that Part II of this book is devoted to them. In Part II we outline and illustrate such skills as attending (professional presence), unbiased listening, working at understanding what clients are saying about themselves, responding to clients with understanding, helping clients explore their concerns more fully, helping them stay focused, and helping them develop new perspectives on their problem situations and unused opportunities. Conversations between helpers and their clients are or should be therapeutic or helping dialogues (Knapp, 2007; Paré & Lysack, 2004; Seikkula & Trimble, 2005). Interpersonal communication competence means not only being good at the individual communication skills but also marshaling them at the service of dialogue. Communication skills and elements of dialogue are addressed at length in Part II of this book.

It would be helpful if clients had the communication skills outlined in Part II and the ability to weave them into constructive dialogues with their helpers. This is often not the case. In fact, many clients get into trouble precisely because they do not know how to establish and maintain healthy interpersonal relationships, which are nourished by effective communication. We live in a society that does not take these skills seriously enough to incorporate them into its formal and informal curriculum. Research also shows that many, if not most people, believe that they are better at interpersonal communication than they really are. Becoming competent in dialogue is a life-long task.

What can helpers do when their clients are poor communicators? They use their own communication skills to help clients engage in dialogue. And they do this without becoming condescending. If Karl does not have all these skills, then Laura can use her skills to help him engage in a dialogue. Furthermore, uncertainty is part of the nature of dialogue. If either party knows the outcome of the conversation before the conversation starts, they may well have a conversation but it will not be a dialogue. Dialogue means that the parties involved “co-create” the outcomes. Laura is not treating Karl’s PTSD. The two of them are collaborating in an endeavor to make his life more livable.

## **6. Integrate the Basic Principles Related to Cognition, Behavior, and Emotions into the Helping Process**

When clients talk, what do they talk about? They talk about their problem situations and their unused opportunities in terms of what they think, what they do, and how they feel all jumbled together. Some approaches to therapy emphasize cognition or what goes on in clients’ minds (Dobson, 2011; Galotti, 2013), others highlight human behavior (Antony & Roemer, 2011; Spiegler & Guevremont, 2015), and still others focus on emotion (Burns, 2012; Greenberg, 2015). In the end, however, every form of therapy deals with the interplay among what goes on in clients’ minds, their behavior, and their emotions (actions, thoughts, and feelings), especially in the social settings of life. In that sense every form of therapy is a cognitive-behavioral-social-emotional endeavor.

When it comes to these three dimensions of human life—the working of the human mind (cognition), what clients do or fail to do both within themselves and in their daily lives (behavior), and the feelings that drive, accompany, or



result from thinking and doing (emotion)—psychological research has come to recognize patterns which have been codified into principles (sometimes called “laws” as in “the laws of human behavior”). Professional helpers use these basic principles to understand clients, help clients understand themselves, and collaborate with them in finding ways to manage problem situations and develop unused opportunities. Competence in these principles is essential (Ellis & Ellis, 2011; Watson & Tharp, 2013).

This book does not define and explore these principles, but training in them should be part of the curriculum of any helper preparation program. If your training program does not offer instruction in these key ingredients, then it is up to you to get it. For instance, Watson and Tharp’s book reviews these principles and their interplay and helps students apply them to their own lives. Charles Duhigg (2014) has written a very useful book on the power of habits, both good and bad. Habits play an important role in everyday behavior and are, therefore, the stuff of therapy. Habits and addictions are often closely related (Lewis, 2016). There are many different forms of addiction besides drug abuse that permeate our lives—for instance, digital (Kaminska, 2017; Lustig, 2017), pornography (Walters & Spengler, 2016), food (Lustig, 2014), falling in love, attachment to sports teams, sex, music we cannot live without, gambling, exercise regimens, work, preferred forms of daydreaming, TV programs, to name a few. Just as the sexual instinct can fasten on to almost anything, we can become addicted to almost anything. Given the many forms of addiction, it is understandable that failure to diagnose and treat addictions is a common helper problem (Liese & Reis, 2016). Some addictions such as exercise regimens enrich our lives, but even these can be pushed too far.

Even though medical treatments can help with some life-limiting addictions (Lyon, 2017), dealing with the psychological dynamics of addiction in terms of thoughts, actions emotions is essential (Kelly, 2016; Marlatt & Witkiewitz, 2009; Miller, P., 2013; Shaffer, 2012).

Understanding of motivation and its role in everyday life in terms of incentives, rewards, and punishment is a very important part of the thinking-doing-feeling triad (Pink, 2009; Thomas, 2000). Positive feelings and emotions motivate us, while negative ones can shut us down. Anxiety (Bourne, 2015; Bray, 2017) and depression (Mayo Clinic Health Letter, 2017; O’Connor, 1999; Pettit & Joiner, 2006) are so common in everyday life that it would make sense to train people at an early age in ways of managing them.

Although *The Skilled Helper* does not pretend to provide any in-depth training in these three sets of interacting principles (cognition, behavior, and emotion), it is filled with examples of clients who run afoul of these principles and of helpers who demonstrate competence in using them to help their clients.

## **7. Use Feedback to Improve the Effectiveness of the Helping Sessions and Clients’ Change Efforts**

Tyler, Pargament, and Gatz (1983) moved a step beyond the consultant role in what they called the “resource collaborator role.” Seeing both helper and client as people with defects, they focused on the give-and-take that should characterize the helping process. In their view, either client or helper can approach the

other to originate the helping process. The two have equal status in defining the terms of the relationship, in originating actions within it, and in evaluating both outcomes and the relationship itself. In the best case, positive change occurs in both parties.

So helping is a two-way street. Clients and therapists change one another in the helping process. Even a cursory glance at helping reveals that clients can affect helpers in many ways. For instance, Liang, a Chinese immigrant, has to correct Timothy, his counselor, a number of times when Timothy tries to share his understanding of what Liang has said. For instance, at one point, when Timothy says, “So you don’t like the way your father forces his opinions on you,” Liang replies, “No, my father is my father and I must always respect him. I need to listen to his wisdom.” The problem is that Timothy has been inadvertently basing some of his responses on his own cultural assumptions rather than on Liang’s. When Timothy finally realizes what he is doing, he says, “When I talk with you, I need to be more of a learner. I’m coming to realize that Chinese culture is quite different from mine. I need your help.”

Feedback is a critical, but too often overlooked, communication skill in the helping dialogue (McClintock et al., 2017; Miller, Duncan et al., 2006; Snyder & Aafjes-van Doorn, 2016). In therapy, two things need to be monitored carefully and continually—first, progress toward life-enhancing client outcomes and second the degree to which therapy sessions are contributing to these outcomes. As to the client’s progress in managing problem situations and developing opportunities, these are the kinds of questions that clients need to ask themselves. Overall, what does progress look like? What progress am I making in terms to getting to the heart of the problem situation? To what degree do I understand what the resolution of the problem situation should look like? What are my goals? How can I clarify these goals? What actions must I take to achieve these goals? How do I start moving in the right direction? What obstacles am I running into and how am I dealing with them? What do I need to do to persist in achieving the life-enhancing outcomes I say I want? Counselors can help clients ask themselves these questions. Prescott, Maeschalck, and Miller (2017), in an edited overview, show how useful feedback can be in a wide variety of helping settings, including private practice, clinics and agencies, child and family therapy, therapy with LGBTQ clients, and counseling in the criminal justice system.

As to the helping sessions themselves these are the kinds of questions that need to be asked. How are we doing? What is going right? What mistakes are we making? How can we make these sessions more productive? What do we need to do to improve our collaboration?

These two kinds of feedback have been studied thoroughly (Duncan, 2010; Lambert, 2010a, 2010b, 2012). Duncan and his colleagues have developed and researched a simple feedback system based on two brief surveys, one given at the beginning of each session and the other administered toward the end of each session. The first survey asks the clients to rate themselves in four broad categories—personal well-being, how things are going with family and other close relationships, how things are going with work, school, and other relationships such as friends, and an overall category called a general sense of well-being. The survey given at the beginning of the first session helps “jump start” the helping



process and acts as a kind of baseline against which between-session progress is determined. The second survey, scored toward the end of each session, deals with within-session satisfaction. In this survey clients indicate what has gone right and what needs further attention in the session itself by rating four broad categories—degree of satisfaction with the helping relationship itself, the degree to which the session addressed the right topics and focused on the clients' goals, how well the approach to treatment fits the clients' needs, and overall satisfaction with the session. Ideally, the surveys stimulate collaborative dialogue, help keep the client in the driver's seat, and make both the sessions and the client's between-session behavior more productive in terms of problem-managing outcomes.

At one point during the first session Laura explains the importance of feedback to Karl and then goes on to describe the survey system outlined above and suggests that they use it. Karl looks at the forms and then dismisses them, saying "I don't think so. It's too much like playing games." Laura does not try to convince Karl to use the forms, but decides to make feedback a more seamless part of the dialogue. About five minutes before the end of the session, she asks, "How do you think we're doing?" Karl hesitates and then says pleasantly, "You're the expert. How do you think we're doing?" She realizes that Karl is not completely convinced that therapy is a good idea. So she shares what she thinks are the highlights of the session and does so in such a tentative way that Karl adds a few comments of his own. She ends by saying, "So I think we're still feeling our way." Karl hesitates again and then says, "That's about right. We're both feeling our way." Laura believes that feedback is essential but is not going to shove a formal system down Karl's throat. She does, however, make another suggestion, one that had proved useful in other cases. She suggests to Karl a "buddy" arrangement similar to those in some Twelve-Step Programs (such as Alcoholics Anonymous). Like Karl, he would be someone who has returned from the wars in Iraq and Afghanistan, who had many of the problems that Karl is facing, but who has come out "the other side" in pretty good shape. For Karl this would be another voice, another relationship that could well be, not therapy, but therapeutic. Karl says that he will think about it. But it remains an option.

At the beginning of each session Laura explores with Karl his sense of the progress toward problem-managing outcomes (or the lack thereof) he is making and what they both need to do to facilitate progress. At the end of each session she helps Karl review the session, what he has learned, and what he needs to do "out there." Miller et al. (2010) see these two kinds of feedback as a way of saying, indirectly, to the client: "Your input is crucial; your participation matters. We invite you to be a partner in your care. We respect what you have to say, so much so that we will modify the treatment to see that you get what you want" (p. 424). In the fourth session Karl says, "You know, we're not using the forms, but we are doing the feedback thing. It helps. So I don't care whether we use the forms or not. It's working for me."

Most of the research on feedback deals with feedback provided by clients. What about feedback from the helper to the client? For instance, should helpers provide feedback to their clients with respect to the quality of their collaboration in the helping sessions or with respect to their between-session behavior? Feedback in this sense is a form of both encouragement and challenge to the client. Does such feedback take the client out of the "driver's seat" or is it an invitation

to clients to take the “wheel” more fully? Is challenge or even an invitation to self-challenge a form of criticism? I deal with challenge or invitations to self-challenge more fully in Part II where I propose that helping is inescapably a form of social influence. It is a two-way social-influence endeavor that does not take the client out of the driver’s seat any more than it makes a helper the victim of a client’s whims. In my view, clients who are never invited to challenge themselves are being shortchanged.

## **8. Come to Grips with the Role That Beliefs, Values, Norms, and Moral Principles Play in the Helping Process**

If helping is to be a social-civilizing and not just an individual-enhancement process, it must be value-driven and ethical. Therefore morality and ethics constitute one of the key ingredients of therapy. I have been criticized by some for not including a more extensive section on ethics in this book. My contention has been that ethics is so important that any kind of abbreviated overview would send the wrong message. I cannot imagine a helper training program that did not include a complete course on values and ethics. And beyond the bare bones of the ACA and APA codes, there are many excellent texts on ethics in the helping professions (Corey, Corey, Corey, & Callanan, 2015; Knapp, 2012; Knapp, Gottlieb, & Handelsman, 2015; Nagy, 2011; Welfel, 2013). So let me lay out the reasoning behind my decision.

The beliefs, values, norms, ethics, and morality package presents an intellectual challenge to the helping professions (Mikulincer & Shaver, 2012). While the helping professions are trying vigorously to demonstrate that they are driven by the rigorous methods of science, it is also true that beliefs, values, norms, ethics, and morality and the cultures in which they are embedded are not scientific terms. The social sciences can study these phenomena as forms of human behavior, but although science can demonstrate the societal usefulness of shared patterns of behavior, science cannot prove their “validity.” By definition science can neither prove nor disprove the existence of God together with the moral injunctions that stem from religious belief systems, but that does not stop both scientists and religion-minded people from trying (Aczel, 2014). I once watched a television debate between an internationally well-known scientist, a committed atheist, and an outspoken Christian apologist. At one point the atheist conceded, “Well, of course, everyone needs a moral compass” at which point social pragmatism entered the debate while science flew out the window.

The American Psychological Association wants psychological treatments to be based on science, but the Association also promotes a strict ethical code. For many people this is not an issue. They find the basis for ethics and morality in religion and culture. Judaism, Christianity, and Islam all have extensive moral codes. But these codes, while similar, do have differences. Injunctions such as “Do not kill” are found in all three, but there are variations. Others turn to cultures for moral codes. Culture can be defined as the interplay between shared beliefs and values that leads to shared norms of behavior that, in turn lead to shared patterns of behavior within members of the culture. But because cultures differ, there are differences in their respective moral codes. For instance, while one culture condemns revenge, another might, under certain circumstances,

see it as a duty. There is no “scientific” answer to the question “Which beliefs-values-norms package is the right one?” Others look beyond both religion and culture and see the emergence of morality among human beings as a bio-social-evolutionary phenomenon (Brooks, 2012; Churchland, 2011; Wilson, 1993).

Still others turn their back on all this theory and take an even more pragmatic approach. If the world’s increasingly growing population of seven plus billion people are to live in some kind of harmony and lead a decent life (however defined), common sense rules and regulations are needed. Many individuals will sense the need for such a pragmatic moral code and do their best to live up to it. And there are laws meting out punishments for those who violate the stated norms. So in many ways beliefs, values, norms, ethics, and principles of morality are not givens but choices. Pragmatists reach a common conclusion: Rules and regulations, whatever their source, are necessary to contain the “fallen angels” of our nature and make social life livable.

There is a way to transcend rather than manage or solve the issues outlined here, a way that avoids the negativity often associated with ethics and morality. Handelsman, Knapp, and Gottlieb (2009) review the work being done on “positive ethics.” They claim, “Positive ethics shifts the emphasis from following rules and avoiding discipline to encouraging psychologists to aspire to their highest ethical ideals” (p. 105). This, they contend, makes for better ethical decision-making. Moving beyond the “First, do no harm” approach, Corey (2008) makes a distinction between “mandatory” and “aspirational” ethics. Aspirational ethics focuses on doing what is in the best interests of clients, a sentiment in keeping with the radical client-centered nature of helping: “Ethics is a way of thinking about becoming the best practitioner possible” (p. 37). Grappling with ethical decision-making is part and parcel of life for both you and your clients. Beliefs, values, behavioral norms, ethics, and morality permeate the helping process. Positive ethics offers a way of grappling on higher ground.

In an American Psychologist article Rogerson and his associates (2011) add fuel to the fire. They discuss the role of “nonrational” processes in ethical decision-making. They take issue with current ethical decision-making models, seeing them as overly rational and based on faulty or inadequate assumptions. These models, they say, ignore nonrational factors such as context, the decision maker’s perceptions, relationships, and emotions. Ethics, they suggest, needs to be reconceptualized.

The “arationality” of beliefs and values is a theme that will not go away. An article in the *Economist* (July 10, 2017, p. 75) focuses on the work of economists Roland Benabou and his Nobel-prize winning colleague Jean Tirole (2016) who, as economists, see beliefs and values as “assets.” The *Economist* summarizes:

In many ways, beliefs are like other economic goods. People spend time and resources building them, and derive value from them. Some beliefs are like consumption goods: a passion for conservation can make its owner feel good, and is a public part of his identity. . . . Other beliefs provide value by shaping behavior . . . [R]eligious asceticism can help one avoid unhealthy habits.

Back to Karl and the decisions he must make based on the values he holds. The beliefs, values, norms, ethics, and morality package pervades all of Karl and

Laura's interactions. As to religion, Karl could be called a semi-lapsed fundamentalist. He is no longer a churchgoer, but aspects of the basic fundamentalist package clings to his psyche, if not his bones. They are part of the person he is. In one session, out of the blue as it were, Karl says, "You know, I pray sometimes. Especially if I get angry." Laura sees this as a positive sign, recalling research on the value of prayer in controlling anger and aggression (Bremner, Koole, & Bushman, 2011). For her, the issue is not a belief system but what works.

Decisions tend to be driven by beliefs and values. Therefore, as decisions are being made, it is important that Karl and Laura focus on what underpins them. When Karl says that he was "perhaps too hasty" in turning his back on his family and pre-war friends, he may be saying he feels guilty. Laura realizes that he feels "out of community," but it is not yet clear what he means by community.

Given all these variables, it is essential that Laura and Karl work together to determine and deal with key issues, which, when faced, explored, and changed, will make a substantive difference in Karl's life. Helping is about managing problems in living and developing unused opportunities, not personality transformation. Karl is a lay expert in Karl, knowing himself, however incompletely, from the inside out. Like all of us he has blind spots which contribute to the complexity-uncertainty dyad, but he, rather than text books on abnormal psychology, is still the best source of knowledge about Karl. Laura, as an expert, has dealt with all these complexities before, but Karl is the decision maker. She can help Karl find his way through these inevitable uncertainties and not be paralyzed by them.

## **9. Help Clients Redo Poor Decisions and Make and Execute Life-Enhancing Decisions**

Consider this case. You are the helper. Your client is a woman with breast cancer who has just been told that the drug she is taking to keep the cancer at bay is weakening her heart. This is a real case (Lagnado, June 5, 2017). What should she do? Should she make the decision? Should she be allowed to make the decision? Should the doctors make the decision? How can you help her?

Any number of popular and more academic books point out the ways in which decision-making defines our lives (Cooper, 2014; Craig, 2015; Hammond, Keeney, & Raiffa, 2015; Iyengar, 2010; Schwartz, 2009). While many dispute the findings of some of these authors, it is indisputable that decision-making is center stage in life and in therapy. If we review any given day of our lives, we realize that we make many decisions, most of them of small or intermediate importance—what to eat for breakfast, whether to return the call of an annoying relative, how to talk with a child who is having problems at school—the things of daily life. There are also big decisional moments. At age 80 which treatment, if any, should I choose for prostate cancer that has been described as "somewhat aggressive"? Shall I keep trying to get my spouse to stop smoking or will that make a somewhat troubled relationship even worse? Shall I convert to the religion of my fiancée? Shall I gather the courage to tell my boss that his style is belittling? Young adults face a whole range of important decisions. Should I move out of my parents' home? Should I move back? Shall I go to college? Should I finish college when things go wrong? What kind of job do I want

and what should my job search look like? Should I live with my girl/boyfriend? Should I get married? Should we have children? Should I go back to school?

As I was writing this chapter, a young woman, let's call her Melinda, called me asking me for "advice." I said to myself, "I don't give advice, but I can help her grapple with the important decision she was making." So I said, "Tell me what's going on." She was in the midst of a job search. Her current job was "OK" (meaning not OK), but it was headed nowhere. She wanted a job that fit her interests (she used the word "passion") more closely. She had just received a call from a former mentor who knew her well. He offered her a senior position in his sales department. She had no real interests in sales, but the idea of getting a senior position with all its perks at an early age certainly had its allure. She also had a great deal of respect for her former mentor and did not want to disappoint him. Her younger brother had been urging her to take the position and deal with "other issues" down the road. We spent an hour talking through all the aspects of her decision-making challenge. At the end of the conversation she said, "Well I think I have made my decision. Thank you very much." Later I found out that she had turned down the offer and had begun a more vigorous search for a job in computer technology and design, areas in which she was both very interested and very competent.

Melinda was not really looking for advice. Rather, it seemed to me, she had already made a tentative decision and wanted to run her thinking by someone she trusted. Decisions run along a continuum from the trivial to the life changing. We are all decision makers. So are our clients. Because decision-making is critical to everyday living, it is also critical in the helping process. When clients come to us, they often learn that they have to make some difficult decisions or that they have to deal with the fallout from poor past decisions. They come when they are afraid to decide at all.

**Therapy: a decision-rich process** Problem management and opportunity development are inseparable from decision-making. They are often presented together (Adair, 2013; Kallet, 2014; Vaughn, 2007). Because both problem management and opportunity development deal with options, decision-making, that is, choosing from among options, is at the heart of helping for both helpers and clients.

**Client decision-making** Clients have to decide many things: to come for help in the first place (unless mandated, say, by a court), to choose to talk about certain issues but not others, to determine what issue or set of issues they want to work on, to determine what a better future looks like, to choose the elements of this future to set goals for themselves, to make plans to achieve these goals, to find the strength, courage, and resources to implement these plans, to tell you when the helping process is working and when it is not, to persevere until they get what they have come for. Part of helping clients become better problem solvers is helping them become better decision makers (Dansereau, Knight, & Flynn, 2013). Clients come to therapy with a decision-making style. Understanding how they make decisions will help you become a catalyst for change. Effective helpers do not make decisions for clients, but they do help clients make decisions that lead to life-enhancing outcomes.

**Helper decision-making** Counselors are in decision-making mode throughout the helping process (Gambrill, 2012; Goode, Tompkins, & Swift, 2016). Helpers choose an approach to therapy and then continually make decisions about how to tailor this approach to their clients during the therapeutic encounter. You as a helper will have many options in the way you interact with clients. Understanding what influences you in making these decisions is a key form of helper self-knowledge. While you want to avoid making decisions for your clients, you do want to help them make life-enhancing rather than life-limiting decisions. You want to help them face up to decisions they are trying to avoid. You want to help them explore the possible consequences—good or bad—of decisions they have made or that they are in the process of making. Wenzel (2013) highlights what she calls “strategic” decision-making on the part of the helper, “a flexible yet evidence-based approach to working through decision points in order to move treatment forward.” By “strategic” Wenzel means decisions that “(1) follow logically from the case conceptualization, (2) are arrived upon collaboratively between the therapist and patient, (3) allow the patient to leave the session with something new, and (4) are seen through in their entirety before their effectiveness is evaluated.” I would add that the “evidence” should often be practice-based rather than experimental-study-based. Some of the “decision points” she addresses include times when a specific intervention is not achieving its desired effect, when the patient does not understand or accept the rationale for the helper’s intervention, or when some crisis calls for a shift in focus.

Helpers need to listen to or stay in touch with their own decision-making style. Responding to clients involves a whole series of decisions. Ongoing research on “naturalistic” or “adaptive” decision-making (Klein, 1998, 2008, 2011; Schraagen, Militello, Ormerod, & Lipshitz, 2008) shows that the kind of “fast” decisions experts such as firefighters and airline pilots make on the spot make sense under two conditions. First, they must be skilled and experienced. In the give-and-take of the helping process, counselors and therapists need to be skilled, experienced, and principled. Second, in the end, uncertainty will always haunt decision-making and helpers need to be prepared for the “complexity and ambiguity” Klein sees at the heart of important decisions.

**The bare essentials of direct decision-making** What follows are the basics or bare essentials of what may be called the Newtonian, or rational, approach to decision-making (Baron, 2001; Galotti, 2002; Hammond, Keeney, & Raiffa, 2015; Harford, 2008; Harvard Business Essentials, 2006; Hastie & Dawes, 2001; Hoch & Kunreuther, 2004). But do not be fooled. Later on we will see that decision-making in everyday life and in helping can come closer to the complexity and messiness of relativity and quantum mechanics.

**Problem Identification and Information Gathering.** An issue, concern, or problem is at the starting point of therapy. The first rational task is to gather information related to the particular issue or concern. It is essential to describe or “frame” these issues accurately. A patient who learns that he has prostate cancer must understand the nature of the disease before he can decide what treatment to choose. What kind of cancer is it? How aggressive is it? What is the most likely progression of this particular type of cancer? What are the treatments like? What will



they accomplish? What are the side effects? What are the consequences of doing nothing? What would another doctor say? How do I handle the shock of the diagnosis? And there many things he can do to get answers to these questions—Internet searches, books and articles, talking to doctors, and talking to patients who have undergone treatment or who have refused treatment. Many patients today routinely mount extensive Internet searches on their medical conditions in order to make better-informed decisions. This does not mean that the information they gather provides ready-made answers to emotion-laden questions.

Problem identification in therapy is different from problem identification in medicine and many other areas of life. The problems themselves are often murky. If applied to Karl, we have the following picture. Karl comes to realize that being a loner, being out of community, is an important part of the problem situation. So in his mind he gathers the information he needs to make a decision about what kind of social life he would like. Before he went into the army he was relatively gregarious. For the most part he enjoyed being with both family and friends. But at root he is a bit of an introvert. So he was not happy when he socialized too much. He said yes to too many invitations. He also realized that when he did socialize, he was relatively passive. But this meant that others would make the decisions in the social encounter—for instance, what to talk about, where to go, how long to stay together, and so forth. This did not sit well. In the army Karl had a few very good friends. They did things together. They counted on one another. They had common interests and talked about them when they got a chance to relax. Karl assembled a lot of information about his social life, including the fact that he did not like being a loner. Somewhat of an introvert—that was all right. But a loner—no.

*Analysis.* The next rational step is processing the information. This includes analyzing, thinking about, working with, discussing, meditating on, and immersing oneself in the information. Just as there are many ways of gathering information, so there are many ways of processing it. Effective information processing leads to a clarification and an understanding of the range of possible choices. “Now, let’s see, what are the advantages and disadvantages of each of these choices?” is one way of analyzing information. This approach assumes that the decision maker has criteria, whether objective or subjective, for comparing alternatives.

Karl analyzed the information he gathered. He took an upside-downside approach. For instance, the upside of being relatively passive in social situations meant that people did not “invade” his space, he felt free to leave if any given gathering was doing nothing for him because people were not counting on his contributions, and he could daydream at will. But as soon as he said these things to himself, he realized how self-centered this kind of “upside” was. He was more of a parasite than a contributor. Choosing to be passive was going beyond “being a bit of an introvert.” But was there an upside to being a bit of an introvert? Yes, he said to himself, “I can listen well, think about what’s being said, and then make some kind of intelligent contribution to the conversation.” He discusses the results of his analysis with Laura.

*Making a Choice.* Finally, decision makers need to make a choice—that is, commit themselves to some internal or external action that is based on the analysis: Anita,

in the middle of a painful divorce, says, “After thinking about it, I have decided to sue for custody of the children.” And, as the fullness of the choice includes an action, she adds: “I had my lawyer file the custody papers this morning.”

There are rational “rules” that can be used to make a decision. For instance, one rule, stated as a question, deals with the consequences of the decision: “Will it get me everything I want or just part?” Values also enter the picture because, from one point of view, values are criteria and incentives for making decisions. “Should I do X or Y? Well, what are my values?” The woman suing for the custody of the children says to herself, at least implicitly, “I value fairness. I’m not going to try to extort a lot of money for childcare. I’ll make reasonable demands.”

In one session Karl says, “I’ve become a loner, but I can’t stay that way. It’s deadly. I wasn’t a loner in Afghanistan. It would have been deadly there. If my buddies could see me now they wouldn’t recognize me. But to tell the truth, I’ve become comfortable, not happy, but comfortable being an introvert. I bother no one. No one bothers me.” This is the beginning of a decision to get back into community even though he does not have a clear idea of what community would look like or how he would go about doing it. That is another phase of the problem-management process.

*Follow Through.* Effective decision-making ends in action. In therapy this means problem-managing and/or opportunity-developing action that leads to life-enhancing outcomes. Otherwise decision-making is just wishful thinking. The longer it takes to implement a decision (stopping smoking, keeping a marriage together), the higher the risk of doing nothing. Counselors can help clients talk through the risk of doing nothing or giving up (McGuire & Kable, 2012). As a first step Karl decides to take up an offer Laura had made early in therapy of talking with someone who has gone through the kinds of experiences he has had in Iraq and Afghanistan with the same crippling effects but who has come out the other side. At the time she made the offer, he said that he would “think about it.” When he thinks of getting back with family or friends, he realizes he does not want to get involved on a superficial level. Small talk and all that. Having some kind of “buddy” (he hated that word) had substance to it and fitted in with what he was trying to do. It could be the beginning of “normalization,” but his kind of normalization.

These, then, are the major steps in what Kay (2011) calls “direct” or rational decision-making. But he claims that most of the time in human affairs it is better to follow what he calls “indirect” (oblique) decision-making and the decision-heavy process we call problem management.

***The irrationality of decision-making*** There are many different versions of the standard, rational decision-making process. However, decision-making, though on the surface a rational process of choosing between reasonably well-researched alternatives (Galotti, 2002), has many pitfalls (Ariely, 2010a, 2010b; Chabris & Chapman, 2010; Kahneman, 2012; Kahneman, Lovallo, & Sibony, 2011; March & Heath, 1994; Van Hecke, 2007; Watts, 2011). In the examples spread throughout this book you will see that the direct or rational process of decision-making described above is not necessarily the stuff of everyday life or of therapy. Social-emotional problem situations are often very complex and determining probabilities when it comes to human behavior is often difficult or even impossible.



The ground is continually shifting. Kay maintains that such situations call for oblique or “indirect” decision-making because of the uncertainties involved.

Oblique problem solvers do not evaluate all available alternatives; they make successive choices from a narrow range of options. Effective decision makers are distinguished not so much by the superior extent of their knowledge as by their being aware of its limitations. Problem solving is iterative and adaptive rather than direct. (p. 13)

Benabou and Tirole (2016), mentioned earlier, discuss the ways that beliefs and values can distort decision-making. Their findings are summarized in an Economist article (July 10, 2017, p. 75).

Because beliefs . . . are not simply tools for making good decisions, but are treasured in their own right, new information that challenges them is unwelcome. . . . “Strategic ignorance” is when a believer avoids information offering conflicting evidence. In “reality denial,” troubling evidence is rationalized away. . . . And lastly, in “self-signaling,” the believer creates his own tools to interpret the facts in the way he wants: an unhealthy person, for example, might decide that going for a daily run proves he is well.

You will see all of these possibilities in your interactions with clients. Helping them challenge their blind spots is, as we shall see in Chapter 7, one of the most important tasks in therapy.

Decision-making is not a straight line. Klein (2009) uses the term “adaptive” to describe the kind of pragmatic decision-making needed in real-life situations riddled with uncertainties.

Most of the research about thinking and decision-making takes place in bright and clear conditions. Most of the advice offered is about how to think and decide when the issues are straightforward. That is not what I am interested in. In this book I will explore how we think and decide in the world of shadows, the world of ambiguity. (p. 6)

Klein goes on to describe and then refute approximately ten commonly held ideas about decision-making. For instance, “The starting point for any project is to get a clear description of the goal.” I would answer “true” to such a statement. But as Klein points out its possible flaws, I move from “true” to “perhaps” or “sometimes.” It is not that this and the other statements are totally without merit.

The ten claims aren’t wrong. They work fine in well-structured situations. They even have some value in complex situations because any given situation has both ordered and complex aspects simultaneously. (p. 11)

Good decision makers tend to be “eclectic.” Decision-making in therapy is as much an art as an application of science. Eclectic decision makers do all the things that direct or rational decision makers do, but they do them differently and continually adapt the process to the context. This “adaptive decision-making” theme permeates this book. Like forecasting (Tetlock & Gardner, 2015) decision-making involves “gathering evidence from a variety of sources, thinking probabilistically, working in teams, keeping score, and being willing to admit error and change course.” In therapy the client and helper constitute the team. Gathering evidence includes exploring blind spots, seeing problems and opportunities contextually, and developing new perspectives. Keeping score means

feedback regarding the process and outcomes of therapy. Probabilistic thinking involves creative thinking about both problem situations and life-enhancing outcomes. In their study Tetlock and Gardner trained participants in the basics of how to think about probabilities in an uncertain world. Within reason we can do the same with clients.

Even though totally rational decision-making in therapy looks more and more like an improbable event and that indirect (oblique, arational, feeling-your-way) decision-making is the norm and necessarily so, still both kinds of decision-making play a role in therapy. Decision-making tends to be a process that is direct and indirect, rational and arational, science and art with both dimensions intermingled like fudge-ripple ice cream. We work with clients to help them crawl out of the decisional pits into which they have fallen or to help them from falling into these pits in the first place. Karl admits that he made a mistake by cutting himself off from family and friends when he returned from Afghanistan. Therefore one of his goals is to get back into community. He has to reconstruct this part of his life. Wanting to get back into community is a decision in itself and the “how” of doing this requires any number of decisions. What kind of community of family and friends does he want? How should he go about reconnecting or making new connections? It will become evident that Karl (and clients in general) will not move in a linear fashion through the rational decision-making process outlined earlier. Problem management and decision-making are often, if not usually, circuitous journeys.

**Decision-making styles** In his book, *Thinking, Fast and Slow*, Nobel Laureate Daniel Kahneman (2012) describes two systems people use to make decisions. System One is fast, intuitive, and emotional. He describes the capabilities, faults, and biases of fast thinking. People are strongly influenced by their intuitive impressions, so it is important to know when we can trust our intuitions. People brag about “following their gut” even though it is often the road to disaster. Karl followed his gut when he quickly decided to leave the army and this proved to be a life-enhancing decision. When he summarily dismissed Laura’s offer of a simple survey-driven feedback system, his fast thinking approach did him no favor. Although System Two, slow thinking, is more deliberative and logical, it can lead to life-enhancing decisions. However, if slow thinking is overused, problem-managing action can grind to a halt.

Assuming that all clients make decisions in the same way is, of course, unthinkable. Understanding different styles is essential to effective helpings. In a recent large study conducted by Teatro, a health-care data-analytics firm, and reported in the *Wall Street Journal* (September 22, 2015, D1–D2) researchers discovered that, generally speaking, women and men have different decision-making styles when trying to determine what to do once they have found out that they have cancer—women with breast cancer, men with prostate cancer. Men tended to be analytical, methodical, and data-driven in their search for treatment options. Women, on the other hand, tended to be more distrustful of assessment data and even of their physicians and went to the Internet not for scientific advice but for stories and advice from other women struggling with breast cancer. Reyna, Nelson, Han, and Pignone (2015) discuss in detail the process of patient decision-making in dealing with cancer. The point here is that both

groups of people and individuals have decision-making styles. Effective helpers, armed with a good understanding of their own decision-making style, get a sense of the client's style and the ways in which that style helps or hinders the management of problem situations. For instance, many clients go instinctively with their "gut" instead of their "head" even when their gut is leading them astray even when faced with important decision (Kahneman, 2012; Lehrer, 2009). Decision-making casts a large shadow and you will do well to understand what lies in that shadow. Both System One (fast, gut) and System Two (slow, head) are comprised of a continuum (somewhat fast, quite fast, very fast). Clients' styles tend to be some kind of mixture of all decision-making factors.

What Karl is like as a decision maker is a key factor in this therapeutic endeavor. It seems that he too often gets caught up in the common irrationalities that plague decision-making. He seems to make decisions, even important ones, quickly with little internal debate or reflection. Is this a deep-seated pattern or is it temporary? To what degree might this interfere with the range of decisions, large and small, required by the problem management process? Laura believes that it would be quite useful to help Karl get in touch with and review what kind of decision maker he is. So she helps him explore his style. Both are surprised when he discovers that he sees his "fast" style as "more masculine."

Even though clients and helpers have decision-making styles, any given decision is influenced by a wide variety of factors both within the client and the helper, in their relationship, and in the context in which the client is making the decisions. When we add the "influencers" described briefly here, the complexity of decision-making becomes obvious. No one escapes. In an edited book on clinical decision-making, Magnavita (2016) notes in his introduction that "even the most self-aware clinicians are susceptible to biases that can influence their decisions and can have a dramatic effect on treatment outcome." Clients have their biases; we have ours.

In the following case we can ask ourselves: "What kind of influencers such as client or helper or third-party bias might affect Brinda's decision making?" The core of the case is real even though much has been changed for the sake of privacy.

Brinda received a degree in design and Internet studies in the United Kingdom, Rohan a degree in business in Scandinavia. They met when they returned to their native country and decided to start a dress and accessories business. They ignored the fact that they were two very different people with very different styles. The first two years there were the usual start-up bumps, but the business did reasonably well. One day Brinda was shocked when Rohan accused her of mishandling funds, focusing too much on design, and failure to understand business realities, in effect blaming her for an undefined lack of progress. "We should be doing much better than we are." She was so shocked that she did not even try to defend herself. In her view Rohan was the culprit. He was narrow minded, poor in relating to customers, suppliers, and employees, and unaware that his managerial style hindered rather than helped the business. She had been wishing that she had started the business on her own. But this was impossible because of financial realities. In the middle of all of this a sudden downturn in the economy made everything worse. Now it was a question of survival. Bankruptcy was around the corner. At her wits end, Brinda sought the help of a consultant-counselor.

Here, in no particular order, are some of the factors that could possibly affect, for better or worse, Brinda's, Rohan's, and the helper's decision-making: contextual factors such as the economy, personal decision-making styles, complexity of problem situation, the importance of the issues to stakeholders, the cognitive-behavioral-social-emotional principles triad embedded in key players, perceptions of risks involved in making choices, beliefs and values, availability of options, differential understanding of problem situation, incentives for action, fear of downside in making choices, tendency toward procrastination, lost-opportunity costs, fear of unintended consequences, realization that "I am not in control," perceived probability of success, perceived probability of failure, back-up plans or the lack thereof, lack of clarity of desired outcomes, time constraints—and the list goes on. If we pick just a few of these and apply them to the case of Brinda and Rohan, what might we have?

- *The Context.* What are the key contextual factors influencing Brinda's decision-making as a whole and any given decision in particular? Brinda is currently providing financial support for her parents. Customers are beginning to drop by the wayside mainly because of Rohan's behavior. Because of the economic downturn the bank is reluctant to loan the business any more money.
- *Values.* What values are driving Brinda's decisions? Good working relationship with family, friends, and colleagues had always been a top priority for Brinda. She thinks that this should be a universal value even though she is smart enough to know it is not. Rohan is much more self-centered. He believes that people are out for themselves. Relationships are a means to an end, not an end in themselves. Money, success—these are among his top values. Brinda values "getting along," while Rohan values "getting his way."
- *The Cognitive-Behavioral-Social-Emotional Triad.* Consider the cognitive-behavioral-social-emotional triad considered earlier in this chapter. The mindsets of the players in this drama have a significant impact. Rohan sees himself as a "big, important" person. He wants to be known as a winner. Brinda, on the other hand, sees herself as a "steady, competent, focused" businessperson. Rohan has some destructive behavioral habits. He tends to take over conversations and crowd out the views of others, including those of Brinda, customers, and suppliers. Brinda spends time "cleaning up his mess." Brinda is strong emotionally but she is beginning to see that she has limits. So she begins to realize that either she or Rohan has to leave the business. There is always a negative emotional edge to Rohan, but he is totally unaware of it. He does not see the end of the relationship coming.

As of this writing, this case has not yet been resolved. It is coming to an end, but it continues to be packed with a range of serious decisions.

## 10. Adopt a Treatment Model Aligned with the Universal Problem-Management Process

Helpers need to become competent in all the basic ingredients of successful therapy outlined here, but they must do more than that. They must use the right mixture of these basic ingredients, that is, they must organize them and tailor them to this client. This is the art of helping. That calls for a treatment model of or an approach to therapy that helps them both organize and tailor

the basic ingredients to service clients' needs. Therefore the treatment model is a key ingredient in therapy, not in itself but because of the role it can play. So it is helpful to determine whether all helping models have something in common that we have not yet reviewed that will help organize and give focus to the ingredients we have reviewed.

***Treatment models as organizers*** There are dozens (by some counts, hundreds) of different approaches to helping. Instead of asking, "Which approach to therapy is the most effective one?" it is better to ask, "How useful is the model in integrating the key ingredients outlined here at the service of clients?" All successful helpers have the ability to tailor the essential ingredients of successful therapy, including their preferred therapeutic model, to their clients and to work collaboratively with them.

Although the research says that it is not the treatment method that is the main driver of success (Wampold, 2010), this does not mean that it is not important. The chosen treatment model helps organize and give focus to both the client's and the helper's resources. Of course, the model or approach must have substance and face validity, that is, it must "make sense," it must look like it might work. The therapist must believe in the model and be both skilled and comfortable in its use. The client in his or her own way must see the approach as reasonable and collaborate with the therapist in its execution. But execution involves all the ingredients of successful therapy.

Let's return to Karl who is suffering from some form of PTSD. Studies on what researchers call "bona fide" psychotherapies for treating PTSD (Benish, Imel, & Wampold, 2007) show that even though each approach has merit, for any given client one approach may be better than others. Tailoring is essential because clients with PTSD symptoms are not homogeneous. Each client is different. Laura realizes that there are dozens, no hundreds, of different approaches to helping, all claiming to be effective. But, as mentioned earlier, she can use the problem-management framework to suggest methods and treatments drawn from a wide range of approaches. But in her practice this isn't a "let's-try-this-and-see-what-happens" approach. The fact that she knows many different evidence-based approaches does not clutter her mind because she uses the problem-management framework to organize them. And although she makes sure that Karl understands what is being offered, she makes sure that she does not dump any of this complexity on Karl.

***Problem management: human universal and key ingredient*** What treatment approach is highlighted in this book? The simple answer is: An approach that is embedded in every other approach. An approach with which clients are already familiar. An approach that can be used as a tool to borrow helpful treatments from any other approach. Sounds too good to be true? Let me explain.

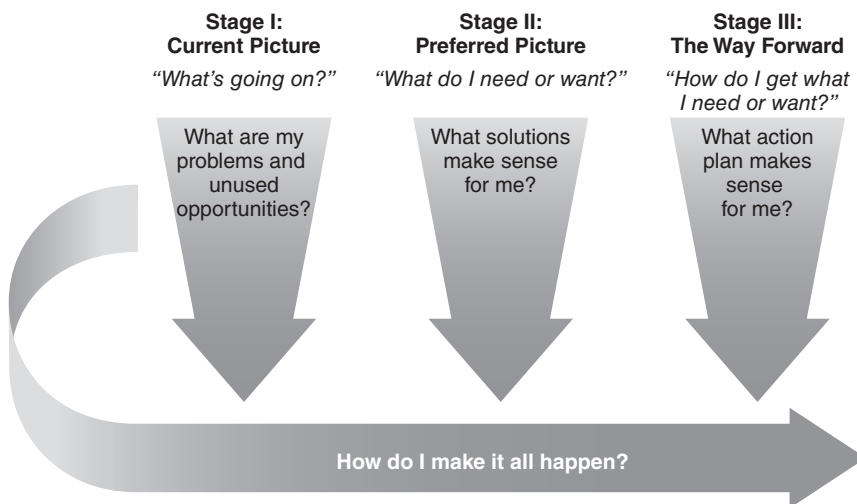
This approach, which I call The Standard Problem-Management Process, poses four questions clients need to ask themselves in their search for life-enhancing outcomes:

- What's going on? "What are the problems, issues, concerns, or undeveloped opportunities I should be working on?" This involves helping clients spell out her or his current picture.

- What does a better future look like? “What do I want my life to look like? What changes would help manage my problem situation and develop unused opportunities? What goals do I need to pursue to manage my problem situation?” This involves helping clients paint their preferred picture.
- How do I get there? “What do I need to do to make the preferred picture a reality? What plan will get me where I want to go? What actions will get me started on the right path?” The plan outlines the actions clients need to take to create a better future. This is the way forward.
- How do I make it all happen? “How do I turn planning and goal setting into the kind of action that leads to the solutions, results, outcomes, or accomplishments that have the impact I am looking for? How do I get going and persevere until I manage my problems and develop my unused opportunities?” The Action Arrow indicates the broad and specific actions clients must take to produce the changes they want. This is the ongoing challenge of implementation.

These questions are in a logical sequence, but do not let the logical sequence fool you. A logical sequence is not necessarily the way things happen in life or in therapy. Everything that has been said about indirect decision-making can be said of problem management. These four questions, turned into three logical “stages” and an “implementation arrow” in Figure 1.1 provide the basic framework for the helping process. But it is a framework, not a formula. The term “stage” is placed in quotation marks because it has sequential overtones that are misleading. In practice the three stages overlap and interact with one another as clients struggle to manage problems and develop opportunities.

*Embedded in People.* Around the world everyone faces problems in living and everyone has overlooked and unused life-enhancing opportunities. The advantage of a problem-management and opportunity-development approach



**FIGURE 1.1**  
Key Problem-Management Questions



to helping is that it is easily recognized across the world. That is, the standard problem-management process seems to be what McCrae and Costa (1997) call a “human universal” or what Norenzayan and Heine (2005), in a stimulating article, call a “psychological universal.” Its logic seems to be embedded in human beings. People do not so much learn the problem-management process as they recognize it. In essence it is already there. It is, to use Orlinsky and Howard’s (1987) term, a “generic” model or framework for helping. Sometimes, when I explain this approach, people say, “Oh, I know that!” Of course they know; it is a basic; its logic is wedded to their bones. The problem is that too many people who say they know it never really use it. It is not part of their lives.

Many years ago, before presenting an earlier version of the helping process outlined in this book to some 300 college students and faculty members in Tanzania, I said, “All I can do is present to you the helping process I teach and use. You have to decide whether it makes sense in your own culture.” At the end of the three-day seminar they said two things. First, the communication skills used in the helping process would have to be modified somewhat to fit their culture. Second, the problem-management helping process itself was very useful.

Since then, this scene has been repeated—in conferences and training events many others and I have presented—over and over again on every continent. The approach, presented in detail in Chapter 2, spells out, in a flexible, step-by-step fashion, a common way human beings think about constructive change. This kind of cross-cultural validation is, as Norenzayan and Heine note, at the heart of universality: “A compelling case for universality can be made when a phenomenon is clearly identifiable in a large and diverse array of cultures” (2005, p. 769). Of course, the Standard Model as outlined here and explored in detail later has to be adapted both to different cultural settings and to different individuals within those settings.

*Embedded in Therapy.* While few models or approaches to helping talk explicitly about problem solving or problem management and the flipside, opportunity identification and development, all treatment approaches use problem-management concepts and language either directly or indirectly. That is, they talk about identifying and exploring problems or problem situations, they discuss the issue of unused strengths and other resources, they talk about goals and the action strategies or plans needed to achieve goals, they point out the difficulties inherent in carrying out plans and suggest ways of overcoming these difficulties. Therefore, in my thinking, the standard problem-management and opportunity-development process is one of the “common factors” in helping. That is, some form of it is found in all successful helping.

In this book I use this problem-management framework as the primary approach to treatment and as a way of organizing the key ingredients of successful therapy outlined in this chapter. Chapter 2 reviews in some detail my version of the Standard Problem-Management Framework. There are many different versions. Some, unfortunately, leave out the Stage-II question: “What kind of future do I want?” The shortened version—“What is my problem and what can I do about it?”—loses the richness of imagining a better future. This truncated version works if the problem is, let’s say, a broken refrigerator. The desired outcome is clear. Problems in human behavior are different. A couple in marriage therapy

can spend time exploring their problems but ultimately need to ask themselves “If we want to be married, what kind of marriage do we want?” Then they can ask themselves, “Well, what do we have to do to create that kind of marriage?”

Even though most approaches to treatment use, directly or indirectly, problem-management language, the profession as a whole has not openly recognized its importance in therapy. You are more likely to find research in problem management and decision-making in business schools than in therapy training programs. The fact that Karl is in some way familiar with the problem-management process that Laura suggests they use helps cut down on complexity and uncertainty. The problem-management process provides a map, but of course the map is not the territory. Laura knows both the map and the territory well because of her experience. But now Karl and the context of his life constitute the territory. They have to chart a course together and agree on course changes as they move along. Even when a general direction is set, the journey itself will take twists and turns. The general direction of their journey together must be set by mutual agreement, but how to get there needs to be worked out. Sometimes the destination itself needs to be altered. There are starts and stops. A degree of uncertainty pervades the entire process. That’s why collaboration and mutual feedback are so important.

## Move from Smart to Wise by Managing the Shadow Side of Helping

LO 1.4

Let me add one more dimension of uncertainty to the helping process. More than intelligence is needed to establish a constructive client-helper relationship and use the problem-management framework and skills outlined in this book well—smart is not smart enough. The helper who understands and uses the framework together with the processes, skills, and techniques that make it work might well be smart, but he or she must also be wise. Effective helpers understand the limitations not only of helping theories, frameworks, and models but also of helpers, the helping profession, clients, and the environments that affect the helping process. It is one thing to understand and factor in the uncertainties or “known unknowns” described briefly in this chapter. It is another to understand and deal with the “unknown unknowns” that lurk in the background of all human endeavors, including helping. The latter unknowns constitute what I call the “shadow side” of life.

The shadow side of helping can be defined as follows:

*All those things that often adversely (and sometimes constructively) affect the helping relationship, process, and outcomes, in substantive ways but that are not identified and explored by helper or client or even the profession itself.*

This definition makes it clear that the shadow side is not the same thing as humanity’s dark side (Bohart, Held, Mendelowitz, & Schneider, 2013), which screams at us every day on our television screens. All human endeavors—social life, business, politics, on and on—have their shadow side. Companies and institutions are plagued with internal politics and are often guided by covert or vaguely understood beliefs, values, and norms that do not serve the best interests of the business, its customers, its employees, or its shareholders. The worldwide



financial crisis brought to light a bewildering list of behaviors that were going on in the shadows of the financial industry for years before the blowup. New discoveries routinely fill the pages of the business press and financial institutions have already paid tens of billions of dollars in fines for illegal behavior. There are now excellent reviews of shadow-side factors that caused (and are still causing) troubles in finance (Kay, 2015).

The helping professions, too, have their shadow side. Consider the amount of disagreement on the nature of therapy, the failure to come to grips with the real differences between the social sciences and the STEM-related sciences, the implications of the fact that such realities as beliefs, values, and morality cannot be scientifically validated—the list goes on. The challenges to the helping professions outlined in Appendix 1 are often part of the shadow side. But shadow-side challenges, managed wisely, can provide benefits. Consider the following analogy. The shadow side of helping is a kind of “noise” in the system. Scientists have discovered that sometimes a small amount of noise in a system, called “stochastic resonance,” makes the system more sensitive and efficient. In the helping professions, noise in the guise of the debate around what makes helping both effective and efficient can ultimately benefit clients. In my thinking, the profession needs more noise related to the best way of rigorously studying human behavior, including therapy. There is some noise, but it is not yet loud enough.

What happened to learning from one another and integration? The search for the truth gives way at times to the need to be right. It is not always clear how all of this serves the needs of clients. Indeed, clients are often enough left out of the debate. Just as many businesses today are reinventing themselves by starting with their customers and markets, so the helping professions should continually reinvent themselves by looking at helping through the eyes of clients.

Wise helpers are idealistic without being naïve. They also know the difference between realism and cynicism and opt for the former. If helpers do not know what is in the shadows, they are naïve. If they believe that shadow-side realities win out more often than not, they are cynical. Helpers should be neither naïve nor cynical about themselves, their clients, or their profession. I describe a cynic as someone who has given up but who, unfortunately, has not yet shut up. Wise helpers pursue a course of upbeat and compassionate realism. They see the journey “from smart to wise” as a never-ending one. And they do not neglect the “smart” part of helping or of everyday living. They continually get better at “separating sense from nonsense,” the subtitle of John Ruscio’s (2005) book *Critical Thinking in Psychology*, an excellent exploration of the value of critical thinking.

*The Skilled Helper* is by no means a treatise on the shadow side of helping. Rather the intent is to get helpers to begin to think about the shadow side of the profession and its professionals. There are signs that the helping professions are beginning to explore their shadow side. An example of that is the book *What Therapists Don’t Talk about and Why* (Pope, Sonne, & Greene, 2006). These authors explore myths and taboos that they see as standing in the way of effective helping. More recently, Chapman and Rosenthal (2016) review behaviors, either on the part of clients or therapists themselves or both, that interfere with

the helping process. As they point out, such behaviors are often unintentional, automatic, or absent-minded. They operate in the shadows. Budge (2016) has edited a Special Issue in *Psychotherapy* on clinical errors. Many of these errors such as those in decision-making stem from shadow-side realities. Books and articles like these are a start. Of course, you may not agree with what these authors have to say (or what I say here), but they provide stimuli for deeper thinking about the helping professions and encourage debate. In my opinion the helping professions need to become, in a positive way, more self-critical. This means coming to terms with the shadow side. The shadow side of life is here to stay.

## Embrace Uncertainty LO 1.5

At first glance it seems odd to use the word “**uncertainty**” when talking about the ingredients of successful therapy. Uncertainty is not in itself an ingredient. Rather uncertainty pervades all of the ingredients that have been mentioned so far. Helpers who understand the uncertainties associated with the helping professions and their processes are in a better position to help clients deal with the uncertainties of their lives. The social sciences want to be included in the STEM group—science, technology, engineering, and mathematics. Indeed the social sciences have elements of all four. In research they use the methodologies of the “hard” sciences to the degree that this is possible. They borrow and use various technologies such as video and the Internet in helping clients. Therapists, in some sense, help clients redesign or “reengineer” their lives. And mathematics and statistics have a large role in psychological research. None of this, however, changes the nature of human behavior. The social sciences, like economics or political science, study various forms of individual and group behavior, but the kind of probability associated with human behavior differs radically from the probability associated with the “hard” sciences. Research in counseling and psychotherapy draws its conclusions but these conclusions are permeated with different kinds of uncertainties. Researchers routinely outline these uncertainties or hesitations at the end of articles. So it is often difficult to translate their conclusions into methods practitioners can use. So some wonder whether expertise in psychotherapy can be nailed down or not. Is it an elusive goal? (Tracey, Wampold, Lichtenberg, & Goodyear, 2014).

However, let us end on a more upbeat note. Duncan (2010) highlights the upside of discord and uncertainty in therapy: “As frightening as it feels, uncertainty is the place of unlimited possibilities for change. It is this indeterminacy that gives therapy its texture and infuses it with the excitement of discovery. This allows for the ‘heretofore unsaid,’ the ‘aha moments,’ and all the spontaneous ideas, connections, conclusions, plans, insights, resolves, and new identities that emerge when you put two people together in a room and call it psychotherapy” (154–155). Orlinsky and Rønnestad (2005) show that the helper’s tolerance for complexity and uncertainty is a vital factor in therapy. Perhaps “tolerance” is the wrong word. Therapists and, at least eventually, clients need to befriend and embrace uncertainty, distill it, learn from it. The world of human behavior is full of uncertainties.

# Review the Problem-Management & Opportunity-Development Process

## LEARNING OBJECTIVES

### 2.1 Review the Stages of Problem Management and Opportunity Development

Help Clients Answer the Four Major Questions Dealing with Change  
Help Clients Deal with the Tasks within Each of the Stages

### 2.2 Be Flexible in the Use of the Problem-Management Process

Move with Clients as They Start and Proceed Differently  
Help Clients Engage in Each Stage and Task in Their Own Way  
Help Clients Move Back and Forth between Stages and Tasks  
Do Not Confuse Flexibility with Mere Randomness or Muddling Through

### 2.3 Learn from Different Versions of the Basic Problem-Management Process

See What a Design Thinking Approach to Helping Has to Offer  
Be Ready to Incorporate Action Learning Approaches to Change

### 2.4 Help Clients Determine Whether They Are Ready for Change

### 2.5 Use the Problem-Management Framework as “Browser”

### 2.6 Use N = 1 to Continually Evaluate the Helping Process

### 2.7 Deal with the Shadow Side of Helping Models

See the Downside of a Lack of a Model or Framework for Change  
Note the Confusion Caused by the Needless Multiplication of Helping Models  
Avoid Fads and Irrational Forgetfulness  
Avoid Rigid Applications of Treatment Methods  
Do Not Fail to Become Increasingly Effective by Assimilating the Best Findings of the Helping Professions

## Review the Stages of Problem Management and Opportunity Development **LO 2.1**

Because all approaches to helping must eventually help clients manage problem situations and develop unused opportunities, it seems logical to start with a flexible, humanistic, broadly based problem-management and opportunity-development model or framework that is, as indicated in Chapter 1, embedded to a greater or lesser degree in all approaches to helping. Of those who write about problem-solving approaches to helping, some use the term explicitly (Bedell & Lennox, 1997; Chang, D’Zurilla, & Sanna, 2004; D’Zurilla & Nezu, 1999, 2001; Elias & Tobias, 2002; Kay, 2011; Nezu, Nezu, Y D’Zurilla, 2013; Nezu, Nezu, Friedman, Faddis, & Houts, 1998), whereas others use some form of the process but not the name (Bertolino & O’Hanlon, 2002; Cormier & Nurius, 2003; Hill, 2014). General problem-solving has a rich research history spanning over 100 years. The fact that the research is scattered does not belie its importance. Years ago Nobel Laureate Herbert Simon and his associates put it nicely:

The work of managers, of scientists, of engineers, of lawyers . . . is largely the work of making decisions and solving problems. It is work of choosing issues that require attention, setting goals, finding or designing suitable course of action, and evaluating and choosing among alternative actions. . . . Nothing is more important for the well being of society than that this work be performed effectively, that we address the many problems requiring attention at the national level . . . at the level of business organizations . . . and at the level of our individual lives. (1986, p. 1)

Problem-solving applied “at the level of our individual lives,” called, variously, social problem-solving or applied problem-solving or personal problem-solving or human problem-solving, has a substantial research base (see the research sections in Chang, D’Zurilla, & Sanna, 2004; D’Zurilla & Nezu, 1999; Heppner, Witty, & Dixon, 2004). Nezu, Nezu, and D’Zurilla (2013) devote an entire chapter to this research base. The universal use of problem-solving together with the evidence-based decision-making that is woven into it in all aspects of human endeavor—business, politics, community living, family life, and day-to-day living—provides in-depth practice-based evidence for the universal usefulness of the standard problem-management model.

Common sense suggests that problem-management models, techniques, and skills are important for all of us, because all of us must grapple daily with problems of greater or lesser severity. Heppner’s work (for a review and summary, see Heppner, Witty, & Dixon, 2004) has focused on people’s appraisal of their ability to cope with personal problems. Confidence in one’s ability to solve problems, the guts to face up to them, and a sense of self-control (especially emotional self-control) can lead in many ways to a richer life. O’Neil (2004), commenting on Heppner and his colleagues’ review, says, “The core of their review is the authors’ passion for helping people learn problem-solving to improve their lives. Helping others solve problems is a passionate part of our mission as counseling psychologists” (p. 439).

Ask parents whether problem-management skills are important for their children, and they say “certainly.” But when you ask where and how their children pick up these skills, the hemming and hawing begins. “Sometimes at home, but

perhaps not that much,” is a common answer. Parents do not always see themselves as paragons of effective problem-solving. “Maybe at school?” is another half answer in the form of a question. Yet review the curricula of our primary, secondary, and tertiary schools, and you will find little about problem-solving that focuses on problems in living. Some say that formal courses in problem-solving skills are not found in our schools because such skills are picked up through experience. To a certain extent, that is true. However, if problem-management skills are so important, one may well wonder why society leaves the acquisition of these skills to chance. A problem-solving or problem-management mentality should be second nature to us. The world may be the laboratory for problem-solving, but the skills needed to optimize learning in this lab should be taught. They are basic. They are too important to be left to chance.

Because all approaches to therapy must eventually help clients manage problems and develop unused resources, the model or approach of choice in these pages is a flexible, humanistic, broadly based problem-management and opportunity-development—a model that is straightforward without ignoring the complexities of clients’ lives or of the helping process itself. Indeed, because the problem-management and opportunity-development process outlined in this book is embedded in almost all approaches to helping, this model provides an excellent foundation for any “brand” of helping you eventually choose.

### Help Clients Answer the Four Major Questions Dealing with Change

As noted in Chapter 1, all worthwhile helping frameworks, models, or processes ultimately help clients ask and answer for themselves the four fundamental problem-management questions. I repeat them here:

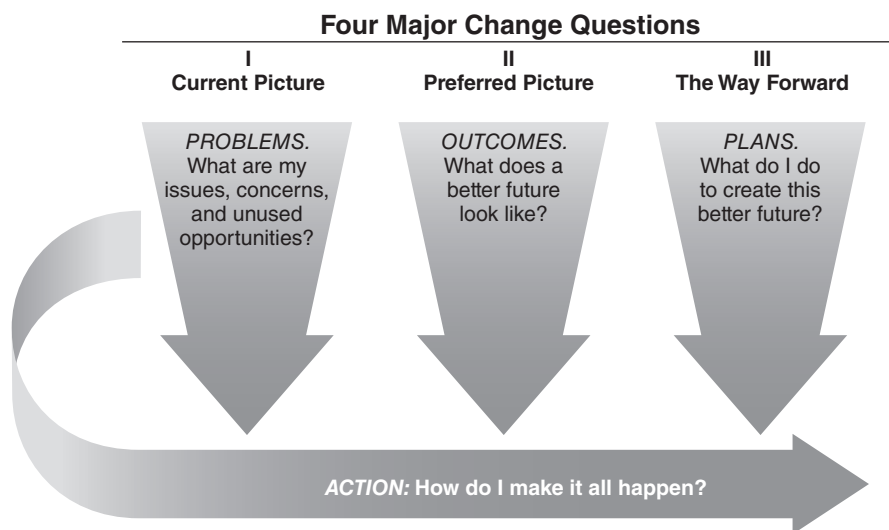
**What’s going on?** “What are the problems, issues, concerns, or undeveloped opportunities I should be working on?” This involves helping clients spell out their *current picture* of the problem situation or unused opportunity.

**What does a better future look like?** “What do I want my life to look like? What changes would help manage my problem situation and develop unused opportunities? What goals do I need to pursue to manage my problem situation?” This involves helping clients paint their *preferred picture*.

**How do I get there?** “What do I need to do to make the preferred picture a reality? What plan will get me where I want to go? What actions will get me started on the right path?” The plan outlines the actions clients need to take to create a better future. This is the *way forward*.

**How do I make it all happen?** “How do I turn planning and goal setting into the kind of action that leads to the solutions, results, outcomes, or accomplishments that have the impact am I looking for? How do I get going and persevere until I manage my problems and develop my unused opportunities? What should I be doing right now?” The Action Arrow indicates the broad and specific actions clients must take to produce the changes they want. This is the *ongoing challenge of implementation*.

These four questions, turned into three logical “stages” and an implementation “arrow” in Figure 2.1, provide the basic framework for the helping process.

**FIGURE 2.1**

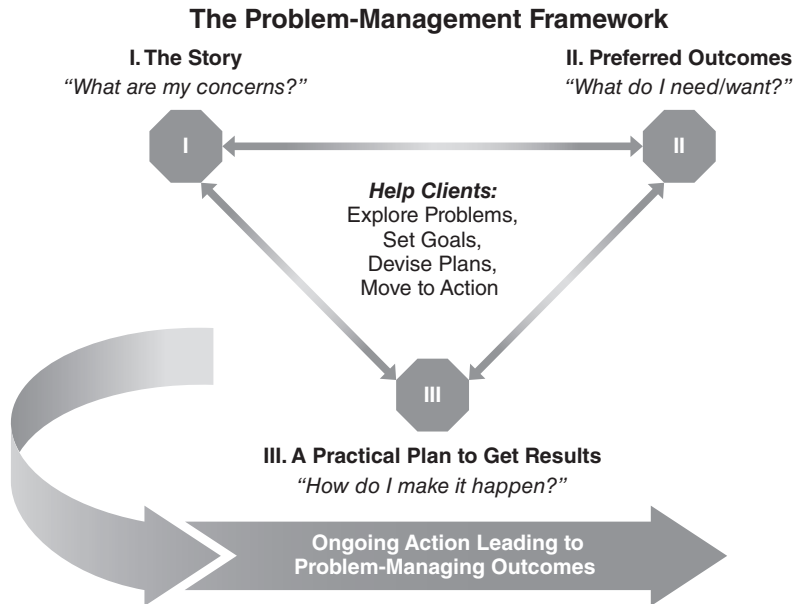
Four Key Problem-Management Questions

Take the example of workers who leave work, usually temporarily, because of common mental health problems such as anxiety, depression, stress, adjustment disorder, emotional exhaustion, and the like. A study (Lagerveld et al., 2012) was done on roughly 170 such workers to determine what kind of therapy proved to be most successful. One half of these workers were treated with a standard evidence-based form of **cognitive behavioral therapy** (CBT). The other half was treated with a form of CBT that emphasized managing the kinds of problems that came up at work and also took a problem-management approach to getting back to work. Those who received the work-focused therapy went back to work on the average of 65 days sooner than workers receiving regular CBT. My best bet is that both forms of therapy had a problem-management focus, but the work-focused form of CBT was much more *explicitly* focused on both ameliorating the mental health disorder *and* getting back to work. The second form of therapy dealt more directly with the problem-management factors in Figure 2.1. It included Action-Arrow components such as homework exercises, including practicing stress-reduction techniques, coming up with ways of altering the work conditions that gave rise to some of the mental health problems, and drawing up an explicit return-to-work plan. The researchers were not out to prove anything about the problem-management process itself, but it is impossible to prove almost anything about successful therapy without at least implicitly referring to elements of the process. These researchers were quite explicit.

Figure 2.2 takes the four elements of the problem-management process and arranges them in a more detailed and dynamic way.

Note that in Figure 2.2 we refer to the problem-management *framework* rather than model and we do so for the following reasons:

- The framework *organizes* all the ingredients of successful therapy outlined in Chapter 1.



**FIGURE 2.2**  
The Problem-Management Process

- It lays out the *geography* of problem management. It helps both clients and therapists know “where they are” in the back-and-forth flow of the helping process.
- The framework is owned by *both* the client and the helper and therefore promotes dialogue and collaboration.
- While it has an ingrained logic to it, it is *systematic but nonlinear*. It is flexible; it has elastic borders. Clients can move back and forth to stages and tasks they find most helpful. Therapists can invite clients to potentially helpful areas that they are overlooking.
- The framework is, therefore, both *rigorous* and *soft-edged*. It is adaptive. It bends with the needs of clients but always remains focused on life-enhancing outcomes.

This theme of flexibility cannot be overstated because many people reject the problem-management process because they experience it as “rigid” and add, “Ordinary people don’t lead their lives that way.” We will explore more about that later. Similar graphics will be used at each of the three stages.

### Help Clients Deal with the Tasks within Each of the Stages

Each of these “stages” involves three “tasks” which are mentioned briefly here and explored in detail in Part II of this book. This overview is cast in terms of questions that clients can ask themselves as they grapple with their problems.

**Stage I: Help clients explore their concerns** In Stage I the tasks are activities that help clients spell out their concerns as clearly as possible with neither too much nor too little detail. These three tasks help clients develop answers to



three sets of questions that outline the work that clients need (with the help of their therapists) to do in order to move forward in the problem-management process.

- *Task A. The Story: Problem Situations.* “What is going on in my life? What are my main concerns?”
- *Task B. The Real Story: New Perspectives.* “As I look more closely, what is really going on in my life? What new perspectives will help me deal with my concerns?”
- *Task C. The Right Story: Key Issues to Work on.* “What should I be working on? Which issues, if handled well, will make a real difference in my life?”

The work that is done in any one of these tasks can stimulate immediate action that leads, at least eventually, to the client’s preferred outcomes.

### ***Stage II: Help clients determine problem-managing outcomes and set goals***

In Stage II therapists help clients imagine the kind of future they want in terms of outcomes and goals. The interrelated tasks of Stage II outline three ways in which helpers can partner with their clients with a view to exploring and developing this better future.

- *Task A. Possibilities.* “What possibilities do I have for a better future? What do I want the future to look like? What do problem-managing outcomes look like?”
- *Task B. Goals/Outcomes.* “What do I really want and need? What solutions are best for me? Which goals, if achieved, will have the *impact* I’m looking for?”
- *Task C. Commitment.* “What am I willing to pay for what I want? Helping myself involves hard work. Am I up to it?”

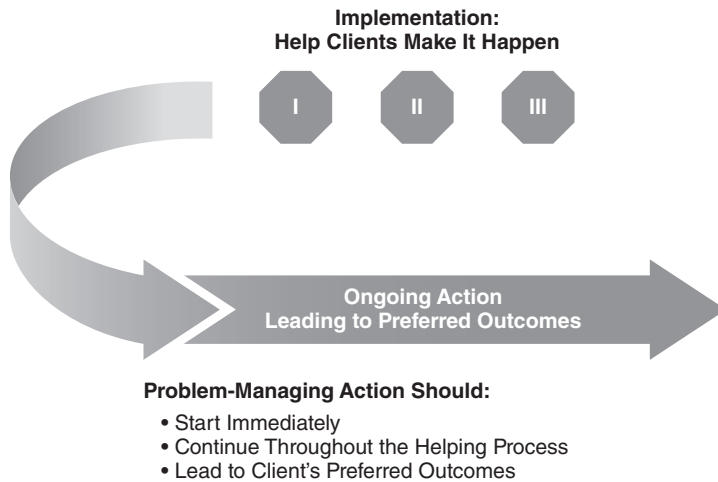
Again, the work that is done in any one of these tasks can lead to actions that in turn lead to the client’s preferred outcomes with the desired life-enhancing impact.

***Stage III: Help clients draw up plans to accomplish goals*** Stage III also has three interrelated tasks. They are directed at coming up with a realistic plan to achieve the goals that lead to problem-managing outcomes.

- *Task A: Possible Strategies.* “What are the possible paths to my goals? What kind of actions will help me get what I need and want? How do I move forward?”
- *Task B: Best-Fit Strategies.* “What strategy or set of strategies is best for me? Which strategies fit my resources?”
- *Task C: Plans to Accomplish Goals.* “What should my campaign for constructive change look like? How do I organize my strategies to accomplish my goals? What do I need to do first? Second? Third?”

The stages, together with the tasks that make them operative, constitute a logical, but, in practice, not necessarily a **linear**, step-by-step process. Why this is necessarily the case will be considered later in this chapter.



**FIGURE 2.3**

The Importance of Ongoing Client Action

### Implementation: Help the Client Make It All Happen

Clients need to ask themselves, “How do I turn goal setting and planning into the kind of action that leads to problem-managing and opportunity-developing solutions, results, outcomes, or accomplishments? How do I get going and persevere until I make it all happen?” Helping is about change. Change demands effort. Figure 2.3 highlights the importance of results-focused action. Helping clients engage in life-enhancing action is at the heart of helping. Chapter 8 in Part III of this book explores in detail the need for client action throughout the helping process.

All three stages of the helping model sit on the “action arrow,” indicating that clients need to act in their own behalf right from the beginning of the helping process. The action arrow is a strong reminder that all three stages of the helping process are about outcomes and the impact these outcomes have on clients’ lives. The bias toward action outlined in Chapter 3 and expanded in Chapter 8 must permeate every stage and every task of the helping process. Stage I is about issues in a client’s past and present that call for change. Stages II and III are about planning for change—setting goals and drawing up plans to achieve these goals—not constructive change itself. Stages I, II, III, and their nine tasks all revolve around planning for change, not change itself. Talking about problems and opportunities, discussing goals, and figuring out strategies for accomplishing goals is just so much talking without any goal-accomplishing action. Change does not emerge magically from therapy; it is hard work. But, as we shall see in subsequent chapters, each stage and task of the process can promote problem-managing and opportunity-developing action right from the beginning.

The need to incorporate action into planning and planning into action will be emphasized throughout this book. The “little actions” needed to get the change process moving at the very beginning of the helping process will be noted and illustrated.

## Be Flexible in the Use of the Problem-Management Process LO 2.2

The logic of problem management presented in these pages might suggest to some that change can be pursued in a prescriptive linear or direct fashion. After all, *The Skilled Helper* process talks about “stages” and “tasks” and assigns linear coding—I, II, III, and A, B, C—respectively, to stages and tasks within each stage. Add in the Action Arrow and there are ten tasks nicely packaged. Indeed, there is a kind of linear logic to this process, but this logic should never be overstated because the logic of problem management is useful only to the degree it serves the needs of clients. To sum up, do not be fooled by the logic of the problem-management process outlined in these pages. Do not impose it on clients. Let clients’ needs guide you in helping them. In subsequent chapters you will be exposed to ten different “moves,” ten different ways of helping clients move toward life-enhancing outcomes. The trick is to learn to use them instinctively and wisely at the service of your clients.

*Obliquity* is the title of a book about, broadly speaking, problem management and opportunity development written by the British economist John Kay (2011). His thesis is this: problem management, especially the kind that involves changing human behavior, is best pursued indirectly rather than linearly. As Kay points out, we rarely know enough about the “moving parts” of important problems to tackle them head-on. Problem management evolves; it is iterative. People are not really that good at linear thinking, especially when involved in messy problem situations. Emotions add to the confusion. An overly direct and linear change process, he says, blinds people to discovering facts that contradict their assumptions. Therefore logic and linearity can stand in the way of common sense and the best kind of intuition. The best solutions to problems often emerge as we try to sift through possibilities, while logic and linearity sometimes keep us locked into solutions we prefer rather than ones that will really work. Kay’s advice: Don’t disregard logic, but use it with caution.

### Move with Clients as They Start and Proceed Differently

Any stage or task of the helping process can be the entry point. For instance, Client A might start with something that he tried to do to solve a problem but that did not work—“I threatened to quit if they didn’t give me a leave of absence, but it backfired. They told me to leave.” The starting point is a failed strategy. Client B might start with what she believes she wants but does not have—“I need a boyfriend who will take me as I am. Joe keeps trying to redo me.” Stage II is her entry point. Client C might start with the roots of his problem situation—“I don’t think I’ve ever gotten over being abused by my uncle.” Stage I is the entry point. Client D might announce that she really has no problems but is still vaguely dissatisfied with her life—“I don’t know. Everyone tells me I’ve got a great life, but something’s missing.” The implication here is that she has not been seizing the kind of opportunities that could make her happy. Opportunity rather than problem is the starting point.

### Help Clients Engage in Each Stage and Task in Their Own Way

Take, for example, clients’ stories. Some clients spill out their stories all at once. Others “leak” bits and pieces of their story throughout the helping process. Still

others tell only those parts that put them in a good light. Most clients talk about problems rather than opportunities. Because clients do not always present all their problems at once in neat packages, it is impossible to work through Stage I completely before moving on to Stages I, II, and III. It is not even advisable to do so. Some clients don't even understand their problems until they begin talking about what they want but don't have. Others need to engage in some kind of remedial action before they can adequately define the problem situation. That is, action sometimes precedes understanding. If some supposedly problem-solving action is not successful, then the counselor helps the client learn from it and return to the tasks of clarifying the problem or opportunity and then setting some realistic goals. Take the case of Woody.

Woody, a sophomore in college, came to the student counseling services with a variety of interpersonal and somatic complaints. He felt attracted to a number of women on campus but did very little to become involved with them. After exploring this issue briefly, he said to the counselor, "Well, I just have to go out and do it." Two months later he returned and said that his experiment had been a disaster. He had gone out with a few women, but the chemistry never seemed right. Then he did meet someone he liked quite a bit. They went out a couple of times, but the third time he called, she said that she didn't want to see him any more. When he asked why, she muttered vaguely about his being too preoccupied with himself and ended the conversation. He felt so miserable he returned to the counseling center. He and the counselor took another look at his social life. This time, however, he had some experiences to probe. He wanted to explore this "chemistry thing" and his reaction to being described as "too preoccupied with himself."

Woody put into practice Weick's (1979) dictum that chaotic action is sometimes preferable to orderly inactivity. Once he acted, he learned a few things about himself. Some of these lessons proved to be painful, but he now had a better chance of examining his interpersonal style much more concretely.

### **Help Clients Move Back and Forth between Stages and Tasks**

Often two or more tasks or even two stages of the process merge into one another. For instance, clients can name parts of a problem situation, set goals, and develop strategies to achieve them in the same session. New and more substantial concerns arise while goals are being set, and the process moves back to an earlier, exploratory stage. Helping is seldom a linear event. In discussing a troubled relationship with a friend, one client said something like this:

Every time I try to be nice to her, she throws it back in my face. So who says being more considerate is the answer? Maybe my problem is that I'm a wimp, not the self-centered jerk she makes me out to be. Maybe I'm being a wimp with you and you're letting me do it. Maybe it's time for me to start looking out for my own interests—you know, my own agenda rather than trying to make myself fit into everyone else's plans. I need to take a closer look at the person I want to be in my relationships with others.

Look carefully. In these few sentences the client mentions a failed action strategy, questions a previously set goal, hints at a new problem, suggests a difficulty with the helping relationship itself, offers, at least generically, a different approach to

managing his problem, and recasts the problem as an opportunity to develop a more solid interpersonal style. Your challenge is to make sense of clients' entry points and guide them through whatever stage or task that will help move toward problem-managing and opportunity-developing action.

### **Do Not Confuse Flexibility with Mere Randomness or Muddling Through**

Focus and direction in helping are also essential. Letting clients wander around in the morass of problem situations under the guise of flexibility leads nowhere. The structure of the problem-management helping process is the very foundation for flexibility; it is the underlying "system" that keeps helping from being a set of random events. In the light of the geography metaphor mentioned earlier, the stages and tasks of the problem-management process are orientation devices. At its best, the helping framework is a shared map that helps clients participate more fully in the helping process. They, too, need to know where they are going.

## **Learn from Different Versions of the Basic Problem-Management Process**

LO 2.3

There are many different ways of answering the four basic problem-management and opportunity-development processes. We will consider two—design thinking and action learning. Both approaches to change offer rich insights into the change process, but the four underlying questions remain the same.

### **See What a Design Thinking Approach to Helping Has to Offer**

**Design thinking** is an approach to problem management and opportunity identification and development that emphasizes innovation and flexibility. While design is often thought of as relating to some kind of product—buildings, automobiles, jewelry, clothing, and so forth—it can also be applied to organizations (Brown, 2009). The management team designs a strategy to give focus and direction to the enterprise or uses design thinking to manage the business disruptions caused by digitization and social media. Individuals who feel they are in a rut can use design thinking to redesign their lives (Birsal, 2015; Burnett & Evans, 2016; Roth, 2015). As Steve Jobs noted, "Design is not just what it looks like and feels like. Design is how it works." More to the point here, therapists can use design thinking in collaboration with their clients to help them manage problem situations and exploit unused opportunities. Thienen and Meinel (2016) outline a design-thinking approach to therapy. The heart of design thinking is a version of the universal problem management and opportunity development process outlined in this chapter and studied in detail in Part III.

There are differences, of course, some negative and some positive. Different design thinking groups use different language in describing the stages of the problem management process, not just different from what is found in this chapter, but also different from one another. This can be confusing and one might ask: Which version of design thinking is the "right" one. The design school at Stanford establishes five "principles" change (Roth, 2015, pp. 11–12).

1. **Empathize.** Use empathy to understand the problem situation, the issues, or the concerns the client, whether organization or individual, is facing. This is in line with Stage I discussed earlier. And empathy is a key value and communication skill, as we will see in later chapters.
2. **Define the problem.** This too is part of Stage I. What is the problem? What is the real problem? What is the right problem, that is, of all the issues, which one or ones are most important to deal with? We need a clear idea.
3. **Ideate.** That is, come up with possible solutions. This is Stage II. The problem here is the word “solutions.” Does this mean the outcome or set of outcomes that will be in place or does it mean that action plan that will put it in place?
4. **Prototype.** I take this to mean the action plan or an initial version of it is actually carried out. In an automotive company it would be a newly designed car. The prototype will tell is whether this is what we want or do we have to go back to the drawing board?
5. **Test and get feedback.** Do something. Try it out. Get the plan going. See what works and doesn’t work. If it is not working iterate, go back to the drawing board. Try something else. Go back to an earlier stage or step.

IDEO (ideo.org, 2015) talks about “human-centered” design in its Field Guide and contends, “all problems, even the seemingly intractable ones like poverty, gender inequality, and clean water, are solvable” (p. 9). The answers, they say, lie within people themselves. The Field Guide uses its own language to describe the problem-management process. There are three “phases”: inspiration, ideation, and implementation, which more or less encompass the three stages of the universal problem management and opportunity development model.

However, the value of design thinking approaches does not lie in the fact that they incorporate the stages and task of the universal problem management model—as change models they had to do that. Their value lies rather in the innovative ways they use the stages and steps of the model. Inventive ways of using the basic stages and steps of the model are invaluable because these innovations make the model useful for any individual with any kind of problem, however “intractable” the problem might at first seem. Furthermore “iteration” in design thinking approaches to change is a must. Doing and redoing the stages and steps, they say, produces better outcomes. So finding innovative ways of using the stages and steps of the model is an unending task. Innovation becomes as important as logic.

Which design thinking programs or processes might help you become more innovative in working with your clients? Here are a couple of examples. Others will be found throughout the text.

Because the logic or universal problem management process is so compelling, some helpers—especially beginning helpers—sometimes, however subconsciously, believe that they should not deviate from the logic described in this chapter. In contrast design thinking therapists see this logic as a framework and use it to understand, at any given time, where they are in the “geography” of helping, but they feel free to move beyond this logic. They will do anything that is ethical and moral to help clients more forward to life-enhancing outcomes.

Peter has a client who is hesitating to “put the cards on the table” with his wife and kids. Peter says, “Let’s go back to where we started.” He has his client relive the problem exploration phase with all its associated agony to help the client find the motivation to act. And it works.

Recall Chad, the man whose friend caught him using pornography who eventually went into counseling with Erin his wife (Chapter 1).

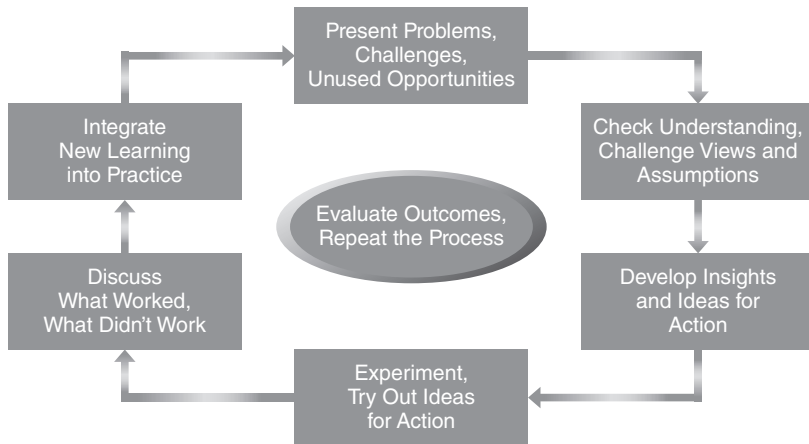
Although convinced that “a little bit of counseling” would help, Chad kept putting it off, even though Erin his wife was ready to go. He would say such things as, “After all, I’m not really sick.” Finally, he signed up with Sylvia for a single session on his own to determine whether this was “really necessary.” Sylvia used design thinking whenever she thought it might help a client. At the beginning of the session Chad expressed a number of his hesitations—“too expensive,” “we can probably do this ourselves,” “we’re not that bad,” and so forth. Sylvia had seen all of this before, so she said, “I think you may be right, so here’s what I’d like to do today.” She outlined a therapy-focused version of a process that the design school program at Stanford used to introduce people to design thinking. It meant going quickly through all the steps of the process from “empathize” to “test and get feedback” (Thienen & Meinel, 2016, see pp. 241–255). She introduced the session by saying, “Trust me. We are going to go through all the steps quickly, only a few minutes for each. You will feel frustrated at times, but you’ll end up with a working understanding of the entire helping process. You might even have some fun. It will help you make your decision to go to counseling with Erin. You can also tell me how you think she might react to the process. But, of course, a ‘no’ is a ‘no.’ I don’t make decisions for my clients.” They go through the entire process interruptions and all. At the end Sylvia says, “Well?” Chad’s reaction was one that the design thinking groups see over and over again. “It was fun. I mean we were talking about really serious stuff, but I was into it right from the start. I got caught up in it. I think that Erin would love every bit of it.” “Who knows,” Sylvia says, “It might be the only session you need.” In fact, they had two sessions with Sylvia, the “training” session plus one more. Chad and Erin then decided they could move forward on their own.

The design thinking literature is diverse, rich, innovative, and confusing. In our opinion a bit more clarity and logic would make it even more useful.

## Be Ready to Explore Action Learning Approaches to Change

**Action learning** is a well-established process for managing problems and unused opportunities. Although it is used primarily in organizations (Marquardt, Leonard, Freedman, & Hill, 2009; Marquardt & Yeo, 2012; Revans, 2011), it can also be applied to individuals by helping them do such things as follows:

- Enhance personal effectiveness and productivity.
- Reflect on and learn from individual experience.
- Enhance personal leadership and soft skills.
- Develop self-confidence and assertiveness.
- Improve awareness of how assumptions, beliefs, attitudes, and organizational interests influence thinking, decisions, and actions.
- Develop Emotional Intelligence (EI): self-awareness, others’ awareness, and adaptability.
- Find the courage to speak up and encourage others to do the same.



**FIGURE 2.4**  
One Version of Action Learning

But, at its heart is the basic problem-management and opportunity-development process, as illustrated in Figure 2.4.

While in business settings, action learning takes place in teams, in essence it also makes sense for the therapeutic “team,” that is, the client and the helper, in group therapy “teams,” and in the “teams” in the client’s real life such as family, friends, and fellow workers. At any rate, collaboration is an important part of action learning.

Action learning helps clients develop core strengths for problem-solving such as the ability to formulate and ask meaningful questions. “Meaningful” here means questions related to goal-focused and goal-achieving action. Clients learn that there are no single, right answers. They learn that answers come from experiments and other forms of action. Like design thinking, action learning focuses on innovation that comes from reviewing and experimenting with a number of possibilities.

Design thinking and action learning are not “pop” approaches to change. MIT has been running action learning labs for some 50 years. Stanford has been a leader in design thinking. Its d.school sees design at the center of creativity: “We believe everyone has the capacity to be creative. The Stanford d.school is a place where people use design to develop their own creative potential.” Therefore the universal problem-management and opportunity-development process is at the heart of these labs. Both schools keep finding ways of enriching this process.

## Help Clients Determine if They Are Ready for Change **LO 2.4**

The problem-management process can be described in terms of the natural **stages of change** and what clients think, feel, and do at each stage. Yankelovich (1992) offered a seven-step process. Prochaska and colleagues (Norcross, Krebs, & Prochaska, 2011; Prochaska & DiClemente, 2005; Prochaska & Norcross, 2010),



seeing helping as facilitating client change, have developed a five-stage process of both client-mediated and helper-assisted change that many helpers find useful. The five stages are precontemplation, contemplation, preparation, action, and maintenance. Both models are forms of the universal problem-management process and both provide insights regarding a client's readiness for change. What follows is my reworked combination of these two models.

1. **Unawareness.** In this stage the person is either unaware that he or she has a problem, or only vaguely aware, or if aware, has no intention of doing anything about it. Sunil says to his apartment neighbors who are complaining about the noise he and his mates make late at night, "It's your problem, not mine. Take some sleeping pills." Clarissa's friends get on her case for overeating even though she has a heart condition, saying, "With your heart the way it is, smoking's going to kill you, not later but sooner." Resistance to recognizing or dealing with a problem is the hallmark of this stage. There is no readiness for change.
2. **Initial awareness.** In this stage clients become aware of an issue or a set of issues, but readiness for change is still very low. For instance, after a number of disputes over household finances, a couple develops a vague awareness of dissatisfaction with the relationship itself. Or consider Clive. He has received two DUI citations. A third will give him mandated jail time. He is vaguely aware that there are legal consequences laying in wait for him. The thought pops into his head from time to time. He even cuts back on his drinking a bit when he has to drive. So he has some initial awareness of possible legal consequences, but he is still unaware of the fact that he is a problem drinker.
3. **Heightened awareness.** In this stage the person knows that he or she has a problem, thinks seriously about doing something about it, but has yet to make a commitment to take action. William says, "I know that smoking is doing me in and I've got to find a way, sooner or later, of giving it up." He is still ambivalent about change. Although clients in this stage think that the price of change still seems too high, they move beyond mere awareness to some significant consideration of change. But serious motivation for change is still missing.
4. **Preliminary actions.** In this stage the person is on the verge of doing something about his or her problem situation or has already tried, however unsuccessfully, to do something about it. The actions taken are often feeble or symbolic. William says, "You know, I'm down to eight cigarettes a day. From two packs!". In this stage the person may be doing such things as trying to avoid temptation and some planning, however meager, for change.
5. **Urgency.** A sense of urgency develops, especially as the underlying problem situation becomes more distressing. Take a married couple that feels the dissatisfaction with their relationship becoming more pronounced. Even small annoyances are now seen in the light of overall dissatisfaction. Or consider when Clive is stopped by an officer for a small infraction—making an illegal turn—and the officer looks up his record and says, "I've

got to give you a Breathalyzer test.” Clive objects, saying, “I haven’t been drinking at all!” This incident shakes him up. Later he says to himself, “I came this close to landing in jail.” He finally has a heightened awareness that he is a problem drinker.

6. **Search for remedies.** Clients begin to look for remedies. However implicitly or perfunctorily, they explore different strategies for managing the problem situation. For instance, clients in difficult marriages begin thinking about complaining openly to their partners or friends, separating, getting a divorce, instituting subtle acts of revenge, having an affair, going to a marriage counselor, seeing a minister, unilaterally withdrawing from the relationship in one way or another, and so forth. The parties may try out one more of these remedies without evaluating their cost or consequences.
7. **Estimation of costs.** The costs of pursuing different remedies begin to become apparent. Someone in a troubled relationship might say to herself: “Being open and honest hasn’t really worked. If I continue to put my cards on the table, I’ll have to go through the agony of confrontation, denial, argument, counter accusations, and who knows what else.” Or he might say, “Simply withdrawing from the relationship in small ways has been painful. What would I do if I were to go out on my own?” Or, “What would happen to the kids?” At this point clients often back away from dealing with the problem situation directly because there is no cost-free or painless way of dealing with it.
8. **Weighing the costs.** Because the problem situation does not go away, it is impossible to retreat completely. And so a more serious weighing of choices takes place. For instance, the costs of confronting the situation are weighed against the costs of merely withdrawing. Often, a kind of dialogue goes on in the client’s mind between steps 7 and 8. “I might have to go through the agony of a separation for the kids’ sake. Maybe time apart is what we need.”
9. **Rational decision.** An intellectual decision is made to accept some choice and pursue a certain course of action. “I’m going to bring all of this up to my spouse and suggest we see a marriage counselor.” Or, “I’m going to get on with my life, find other things to do, and let the marriage go where it will.”
10. **Rational-emotional decision.** However, a merely intellectual decision is often not enough to drive action. So the heart joins the head, as it were, in the decision. One spouse might finally say, “I’ve had enough of this! I’m leaving. It won’t be comfortable, but it’s better than living like this.” The other might say, “It is unfair to both of us to go on like this; and it’s certainly not good for the kids,” and this drives the decision to seek help, even if it means going alone. Decisions driven by convictions and emotion are more likely to be translated into action.
11. **Serious action.** In this stage individuals are involved in life-enhancing change and actually put time and effort into modifying their dysfunctional behavior. Change at this stage tends to be visible and is recognized by others. Modification of the undesirable behavior to an acceptable standard through systematic effort is the hallmark of action.

12. **Maintenance.** In this stage the person consolidates his or her gains and works to avoid relapse. This stage can go on for a long time, even a lifetime, for instance, for the person who fights the urge to smoke every day. A married couple might continually look for ways to “reinvent” their marriage. Clive not only stops drinking but also joins Alcoholics Anonymous to make sure that he stays dry by attending a meeting every day. “I can’t afford another drink.”
13. **Relapse.** Of course, people are prone to relapses. There is a difference between a minor lapse, a relapse, or a total collapse into the old way. Clive is out with some friends who have made fun of his being in AA, saying such things as “I didn’t know they accepted children.” He gets drunk, but his friends take him home. The person can learn from lapses. The next morning Clive says to himself, “I thought I could go out with my drinking buddies and not drink. How stupid can I get?” A relapse or total collapse can mean moving back to a previous stage or even starting the whole process over. Clive cannot afford this scenario and returns to AA.

If this process is in the back of your mind, it can help you meet clients “where they are” both psychologically and in the overall geography of change and tailor the problem-management process to their needs. But remember, this is a conceptual framework to help you work with clients. Becoming preoccupied with a framework is a disservice to clients.

## Use the Problem-Management Framework as “BROWSER” LO 2.5

How do helpers go about borrowing from a range of therapeutic approaches and stitch them together? The problem-management process in this book can be used as a tool—a “browser,” to use an Internet term—for mining, organizing, and evaluating concepts and techniques that work for clients, no matter what their origin. There are examples of this throughout the book.

- **Mining.** First, helpers can use the problem-management model to mine any given school or approach, “digging out” whatever is useful without having to accept everything that is offered. The philosophy, communication skills, stages, and tasks of the model serve as tools for identifying methods and techniques that will serve the needs of clients.
- **Organizing.** Second, because the problem-management model is organized by stages and tasks, it can be used to organize the methods and techniques that have been mined from the rich literature on helping. For instance, a number of contemporary therapies have elaborated excellent techniques for helping clients identify blind spots and develop new perspectives on the problem situations they face. As we shall see, these techniques can be organized in the communication skills section dealing with challenge (Chapters 6 and 7).
- **Evaluating.** Because the problem-management model is pragmatic and focuses on outcomes of helping, it can be used to evaluate the vast number

of helping techniques that are constantly being devised. The model enables helpers to ask in what way a technique or method contributes to the “bottom line,” that is, to outcomes that serve the needs of clients.

- **Incorporating.** Finally, the best ideas can be incorporated into the helper’s ever evolving framework—replacing outmoded ideas, correcting flawed ideas, enhancing viable ones, and generally enhancing the helping process at the service of clients. Every edition of this book has done precisely that. As I mentioned earlier, sometimes people ask me, “Why are you doing a new edition? It’s a good book just as it is.” The question mystifies me.

The problem-management and opportunity-development model can serve these functions because it is an open-systems model, not a closed school. That is why I now refer to it as a framework rather than a model. Although it takes a stand on how counselors may help their clients, it is open to being corroborated, complemented, and challenged by any other framework, approach, model, or school of helping. The needs of clients, not the egos of model builders, must remain central to the helping process. Our clients deserve “best practice,” whatever its source.

## Use $N = 1$ to Continually Evaluate the Helping Process LO 2.6

In the light of the importance of feedback discussed in Chapter 1, how do helpers using the problem-management and opportunity-development framework evaluate what is happening with each client? By making each case a “mini-experiment” in itself. In psychological research there has been a long history of what are called  $N = 1$  or **single-case research designs** both to evaluate practice and conduct research (Blampied, 2000; Borckhardt, Nash, Murphy, Shaw, & O’Neil, 2008; Elliott, 2002; Hilliard, 1993; Kazdin, 2010; Lundervold & Belwood, 2000; Sharpley, 2007). It’s not enough to know that helping in general works. We have to know how well it is working in each case. Jay Lebow (2002) puts it this way: “A clinician can carry out with any individual client a method researchers call the ‘single-case design’—which is simply a more formal and systematic way of documenting what he or she does anyway” (p. 63). He (like Duncan, 2011) recommends using questionnaires to document the changes that occur, both in therapy and in the client’s day-to-day life. There is a caution, however. Bangert and Baumberger (2005) argue that although  $N = 1$  is the most relevant design for practicing counselors; few are adept in using it.

In many helping models, evaluation is presented as the last step in the model. However, if evaluation occurs only at the end, it is too late. As Mash and Hunsley (1993) noted, early detection of what is going wrong in the helping process is needed to prevent failure. They claimed that an early-detection framework should be theory based, ongoing, practical, and sensitive to whatever new perspectives might emerge from the helping process. The problem-management and opportunity-development framework outlined in this chapter fills the bill. It is a tool to check progress throughout the helping process. As we shall see, it provides criteria for helper effectiveness, for client participation, and for assessing outcomes.

## Deal with the Shadow Side of Helping Models **LO 2.7**

This book outlines a framework for helping that is rational, linear, and systematic. What good is that, you well might ask, in a world that is often irrational, nonlinear, and chaotic? One answer is that rational frameworks help clients bring much-needed discipline and order into their chaotic lives, especially when these frameworks are culturally flexible. Effective helpers do not apologize for using such frameworks, but they also make sure that their humanity permeates them. Also the programs and processes of design thinking can take the edge off the logic of problem management. Besides the broad shadow-side themes mentioned earlier, there are a number of specific shadow-side pitfalls in the use of any helping model.

### See the Downside of a Lack of a Model or Framework for Change

Some helpers “wing it.” They have no consistent, integrated model of treatment that they have made their own. Some use a version of the problem-management process outlined in these pages but do not seem to know that that is what they are doing. Professional training programs often offer a wide variety of approaches to helping drawn from the “major brands” on offer. If helpers-to-be leave such programs knowing a great deal about different approaches but lacking an integrated approach for themselves, then they need to develop one quickly. The problem-management/opportunity-development framework is a good place to start because it is inevitably at the core of other helping models. But remember, research shows that helpers need to have a method of treatment in which they both believe and are competent and which they share with clients.

### Note the Confusion Caused by the Needless Multiplication of Helping Models

Institute a computer search and you will soon discover that there are dozens, if not hundreds, of methods or treatments or approaches to helping, all of them claiming a high degree of success. While it is important to have a thorough understanding of the disorders you are trying to help clients manage, the thought of multiple models of almost every known psychological disorder is a thought too far. Likewise, while it is important to understand the developmental tasks and challenges of various age groups, having one or more model of therapy for each age group and sometimes subgroups within each major group from childhood through old age is, I might say, a “stretch.” Include helping approaches around such psychological terms as emotions, mindfulness, motivation, strengths, and the like, it is no wonder the number soars into the hundreds. Don’t get me wrong. I am not insinuating that there is nothing of value in what these authors have to say. Far from it. But there must be a better way of distilling and organizing the research findings and clinical wisdom of our profession.

### Avoid Fads and Irrational Forgetfulness

The helping professions are not immune to fads. A fad is an insight or a technique that would have some merit were it to be integrated into some overriding model or framework of helping. Instead it is marketed on its own as the central,

if not the only meaningful, intervention needed. A fad need not be something new; it can be the “rediscovery” of a truth or a technique that has not found its proper place in the helping tool kit. Rachman (2008) puts it well: “The market for ideas—like the market for shares—always overshoots. Ideas become fashionable and get pushed to their logical conclusions and beyond, as their backers succumb to ‘irrational exuberance.’ Then comes the crash” (p. 13). Helpers become enamored of these ideas and techniques for a while and then abandon them. There will always be “hot topics” in helping. Note them and integrate whatever you find useful into a comprehensive approach to your clients. The proponents of many new approaches to helping make outrageous claims. Don’t ignore them, but take the claims with a grain of salt and test the approach.

The opposite—what might be called “irrational forgetfulness”—is also a problem. Really good ideas are highlighted for a while, and then shoved in a drawer rather than being further developed and incorporated into psychological practice. There is little talk in the helping literature these days about the “laws of human behavior” (Watson & Tharp, 2014) based on an understanding of incentives, rewards, and punishment. “Cognitive dissonance” is seldom heard, although a popular book has resurrected this useful concept (Tavris & Aronson, 2007).

### **Do Not Fail to Share the Helping Model with Clients**

When it comes to sharing the helping process itself, some counselors are reluctant to let the client know what the process is all about. Of course, helpers who “fly by the seat of their pants” cannot tell clients what it is all about because they do not know what it is all about themselves. Still others seem to think that knowledge of helping processes is secret or sacred or dangerous and should not be communicated to the client, even though there is no evidence to support such beliefs (Duncan et al., 2010). If the client is to be in the driver’s seat, he or she has to have a fundamental grasp of the helping process and be encouraged to make decisions about and within that framework.

Both implicit and explicit contracts govern the transactions that take place between people in a wide variety of situations, including marriage (in which some but by no means all of the provisions of the contract are explicit) and friendship (in which the provisions are usually implicit). If helping is to be a collaborative venture, then both parties must understand what their responsibilities are. Perhaps the term *working charter* is better than contract. It avoids the legal implications of the latter term and connotes a cooperative venture.

To achieve these objectives, the working charter should include, generically, the issues covered in Chapters 1 through 3—that is, (a) the nature and goals of the helping process, (b) an overview of the helping approach together with some idea of the techniques to be used, (c) a sense of the flexibility built into the process, (d) how this process will help clients achieve their goals, (e) relevant information about yourself and your background, (f) how the relationship is to be structured and the kinds of responsibilities both you and the client will have, (g) the values that will drive the helping process, and (h) procedural issues. “Procedural issues” refers to the nuts and bolts of the helping process, such things as where sessions will be held and how long they will last. Procedural limitations should also be discussed—for instance, ground rules about whether the client



can contact the helper between sessions. “Ordinarily we won’t contact each other between sessions, unless there is some kind of emergency or we prearrange it for a particular purpose.” Manthei and Miller (2000) have written a practical book for clients on the elements of a working charter. There is some evidence that charters also work with the seriously mentally ill (Heinssen, Levendusky, & Hunter, 1995).

Helping should not be a “black box” for clients. They have a right to know what they are getting into (Heinssen, 1994; Heinssen, Levendusky, & Hunter, 1995; Hunter, 1995; Manthei & Miller, 2000). How to clue clients into the helping process is another matter. Helpers can simply explain what helping is all about. A simple pamphlet outlining the stages and steps of the helping process can be of great help, provided that it is in language that clients can readily understand. Just what kind of detail will help will differ from client to client. Obviously, distracting detail from the beginning should not overwhelm clients. Nor should highly distressed clients be told to contain their anxiety until helpers teach them the helping model. Rather, the details of the model can be shared over a number of sessions. There is no one right way. Reis and Brown (2006) created a short video for clients entering therapy. The video introduces the overall goals of therapy and shows clients how they might best benefit from it. So use your imagination. In my opinion, however, clients should be told as much about the helping process as they can reasonably assimilate.

### **Avoid Rigid Applications of Treatment Methods**

Some helpers buy into a model early on and then ignore subsequent challenges or alterations to the model. They stop being learners. The “purity” of the model becomes more important than the needs of clients. Other helpers, especially beginners, apply a useful helping model too rigidly. They drag clients in a linear way through the model even though that is not what clients need. All of this adds up to excessive control. Effective models effectively used are liberating rather than controlling.

### **Do Not Fail to Become Increasingly Effective by Assimilating the Best Findings of the Helping Professions**

I remember the first time I gave a talk to a group of experienced helpers. I soon found out that they knew little about the research going on within the helping professions. I was surprised. Even a bit shocked. But let me start with a caveat. For all I knew, these practitioners may well have been very successful at what they were doing and my shock was more related to my being an academic twit. However, one would think that staying in touch with relevant research in both the theory and practice of helping would be high on the list of helpers who wanted to increase their competence, but this does not seem to be the case. Boisvert and Faust (2006), in a study of over 180 practitioners, found a disconnect between what they think the research says and what it actually says. Many practitioners think that much, if not most, of the research is irrelevant to their practice.

But another study made me think. Cook and her colleagues (Cook et al., 2009) found that “the greatest influences on psychotherapists’ willingness to learn a new treatment were its potential for integration with the therapy they



were already providing and its endorsement by therapists they respected. Clinicians were more often willing to continue to use a new treatment when they were able to effectively and enjoyably conduct the therapy and when their clients liked the therapy and reported improvement” (Cook et al., 2009, p. 671). That is, many practitioners may well look skeptically at the current flood of research and then take a more commonsense approach.

This is a short but certainly not an exhaustive list of shadow side factors relating to helping models and their use or abuse.



# Commit Yourself to the Helping Relationship and the Values That Drive It

### LEARNING OBJECTIVES

#### 3.1 Understand What Makes Helping Relationships Work

- Start with the Importance of the Relationship Itself
- See the Relationship as a Means to an End
- Make the Relationship a Working Alliance
- Get Off to a Good Start
- Keep the Client's Points of View and Preferences Center Stage
- Approach the Relationship as Forum for Relearning
- Reimagine Helpers and Clients as Entrepreneurs

#### 3.2 Determine the Key Values That Drive the Working Alliance

- See Values as Tools of the Trade
- Determine the Values Inherent to Successful Helping

#### 3.3 Prize Respect as the Foundation Value

- Avoid Behaviors That Show Disrespect
- Engage in Behaviors That Show Respect

#### 3.4 Make Empathy the Primary Orientation Value

- Consider This Brief Overview of Empathy as a Value
- See Empathy as a Two-Way Street
- Embrace Empathy as Radical Commitment

#### 3.5 Develop a Proactive Appreciation of Diversity as a Sense-of-the World Value

- Appreciate the Role of Culture, Personal Culture, and Values
- Acquire Competencies Related to Diversity and Culture

#### 3.6 Develop a Bias toward Action as an Outcome-Focused Value

- Understand the Nature of Self-Efficacy
- Promote Self-Responsibility by Helping Clients Develop and Use Self-Efficacy
- An Amazing Case of Client-Initiated Action

#### 3.7 Influence Clients to Embrace Self-Responsibility

- Realize That Helping Is a Social Influence Process
- Accept Helping as a Natural Two-Way Influence Process

## Understand What Makes Helping Relationships Work

### LO 3.1

This chapter addresses how to relate to clients. It contains many suggestions, but do not get lost in the detail. One way of proceeding is to read this chapter thoughtfully but quickly. Then reread it as you move through Part II and Part III of this book.

An enormous amount of research on the nature of the helping relationship has been done over the past years (Hilsenroth, 2014; Kivlighan et al., 2016; Norcross, 2011; Xu & Tracey, 2015; Zilcha-Mano et al., 2015), though, unsurprisingly, some of its findings are contradictory. No attempt is made in this chapter to dissect this research and provide a critical review. Rather, we focus on the basics. What do helpers need to know about the relationship? What do clients need to know? How can counselors help clients do their part in establishing a collaborative relationship? What needs to be done to make sure that the relationship serves life-enhancing outcomes for clients. In my view, the research findings often do no more than confirm common sense, which, admittedly, is not a “scientific” term. But clients certainly understand the term common sense. And if you think of the words related to the term—discretion, levelheadedness, practicality, prudence, sense, wisdom, street smarts, acumen, judgment, care, caution, circumspection, and the like—you get the idea. And common sense might be misnamed because, as some say, it isn’t that common.

Although theoreticians, researchers, and practitioners alike, not to mention clients, agree that the relationship between client and helper is important, there are significant differences as to how this relationship is to be characterized and played out in the helping process. Some stress the relationship itself, whereas others highlight the work that is done through the relationship. Some use the term relationship, while others prefer the term “working alliance.” Although different researchers define terms such as “relationship” and “alliance” differently, certain themes such as “collaboration” dominate. Even then what collaboration looks like differs from author to author. The purpose of this section is not to reconcile differences but to give helpers a clinical “feel” for the basics of what a good (that is a productive) relationship looks like. There is no one right way of developing a helping relationship. Even though there are fundamental principles, you and each client have to co-discover and co-develop the “right” relationship for that encounter.

### Start with the Importance of the Relationship Itself

All of us establish relationships of one kind or another throughout our lives. One way of looking at any relationship, including a helping relationship, is to consider what each party “brings to the table,” as it were, and how these offerings interact. Both helper and client have a set of personality traits and personal cultures (discussed later in this chapter) that affect how they go about establishing and maintaining relationships. If helper and client were to meet at, let us say, a party or conference before therapy began, the relationship would be a result of what each would “bring to the party.” That is, neither would be acting from a

role—the helper role or the client role. The point is that the helping relationship can be affected by the package of human elements each brings to the helping encounter. Norcross (2011) puts it simply: “Remember: The relationship is far broader and inclusive than the [working] alliance alone” (p. 120). It follows that the better both clients and helpers understand themselves in terms how they establish and maintain relationships the better they might be in establishing a working alliance in therapy. The word “might” is important here.

Most approaches to therapy affirm the importance of the helping relationship, but not in the same way. In a different mode, Carl Rogers (1951, 1957; Kirschenbaum, 2009), one of the great pioneers in the field of counseling, emphasized the quality of the relationship in representing the humanistic-experiential approach to helping (see Kelly, 1994, 1997). Rogers claimed that the unconditional positive regard, accurate **empathy**, and genuineness offered by the helper and perceived by the client were both necessary and often sufficient for therapeutic progress. Through this highly empathic relationship counselors, in his eyes, help clients understand themselves, liberate their unused resources, and manage their lives more effectively. Rogers’s work started the widely discussed client-centered approach to helping (Rogers, 1965).

On the other hand, in psychoanalytic or psychodynamic approaches, “transference” and “countertransference”—the complex and at first unconscious interpersonal dynamics between helper and client that are rooted in the client’s and even the helper’s past—are central (Zilcha et al., 2014). Resolving these often murky dynamics is, some say, intrinsic to successful therapeutic outcomes.

### See the Relationship as a Means to an End

Some see the helping relationship as very important but still as a means to an end. This makes sense because life-enhancing client outcomes, as noted in Chapter 1, are what helping is all about. The cognitive-behavioral tasks of the helping process are accomplished, as Tursi and Cochran (2006) have noted, in a person-centered relational framework. In this view, a good relationship is practical because it enables client and counselor to do the work called for by whatever helping process is being used. Overstressing the relationship, they say, is a mistake because it obscures the ultimate goal of helping: managing problem situations and developing life-enhancing opportunities. This goal won’t be achieved if the relationship is poor, but if too much focus is placed on the relationship itself, both client and helper can be distracted from the real work to be done.

### Make the Relationship a Working Alliance

“The alliance refers to the quality and strength of the collaborative relationship between client and therapist” (Norcross, 2011, p. 120). Although the term working alliance has a long history and a number of different interpretations (Horvath et al., 2011), it can be used to bring together the best of the empathic-relationship-in-itself and relationship-as-means-to-achieving-desired-outcomes. Bordin (1979) defined the working alliance as the collaboration between the client and the helper based on their agreement on the goals and tasks of counseling. Horvath and his associates (2011) add a dynamic-process touch: “The alliance represents an emergent quality of partnership and mutual collaboration between therapist

and client. . . . Its development can take different forms and may be achieved quickly or nurtured over a longer period of time. . . (p. 11).

***The collaborative nature of helping*** In the working alliance, helpers and clients are collaborators. Helping is not something that helpers do to clients; rather, it is a process that helpers and clients work through together (Frankel, 2007). Helpers do not “cure” their patients. Both have work to do and both have responsibilities related to outcomes. Outcomes depend on the competence and motivation of the helper and the client, and on the quality of their interactions. Helping is a two-person team effort in which helpers need to do their part and clients theirs. If either party refuses to play or plays incompetently, then the entire enterprise can fail.

***Guiding principles for alliance behavior*** Because the term working alliance is a concept, an abstraction, it takes on life and clinical significance through the behavioral principles that make it a reality. Here are some alliance-focused principles:

- *Alliances emerge.* Don’t try to build an alliance. Rather make sure that everything you do contributes to a spirit of collaboration and partnership. When Karl and Laura (see Chapter 1) interact collaboratively and constructively in exploring Karl’s tendency to run away from closer interpersonal relationships, the alliance “emerges” and grows.
- *Track the client’s evolving needs and wants.* Make an effort to understand the client’s preferences and modulate accordingly. Remember that both of you are on a collaborative search for the right relationship. When Karl summarily rejects the survey approach to monitoring the helping process and outcomes, Laura does not push the issue. There are other ways to get feedback. And some clients need to get comfortable with the relationship before adding what they might see as “extras.”
- *Focus on resources.* As you move into the helping process, make sure that you are getting in touch with not just the client’s problems and concerns but also the resources and expectations the client brings to the helping endeavor. Effective helpers begin focusing on the client’s strengths right from the beginning. Right from the start Laura says to herself, “This guy seems to have a lot going for him, but I’m not sure if he is in touch with his considerable resources.”
- *Don’t be surprised at differing views of the relationship.* Your view of how the relationship is evolving may not be the same as the client’s view especially in the early stages of the relationship. Look for cues indicating the state of the relationship throughout the helping endeavor. The fact that Karl issues begins to respond more positively to Laura’s invitations to self-challenge tells her that these invitations are an important part (he used the term “gutsy talk”) of their relationship.
- *Ups and downs are common.* Do not be surprised about ups and downs in the relationship. That happens in everyday life. When Laura invites Karl to look at the consequences of being “out of community,” Karl sulks. Both of them

have to work at re-establishing equilibrium. Horvath and his colleagues see these ups and downs as “normal” variations, which, if “attended to and resolved, are associated with good treatment outcomes” (p. 15).

The communication and relationship building skills essential to all the above are outlined and illustrated in Part II. Some ask the question: Is such an alliance therapeutic in itself, that is, does it lead to life-enhancing outcomes on the part of the client, or is it merely facilitative in that it opens up the way for the other common factors to work (Zilcha-Mano, 2017)? We tend to say, YES. So there.

### **Get Off to a Good Start**

Miller, Duncan, et al. (2006, p. 5) noted that “research has found that client change occurs earlier rather than later in the treatment process, and that the client’s subjective experience of meaningful change in the first few sessions is critical. If improvement in the client’s subjective sense of well-being does not occur in the first few sessions, then the likelihood of a positive outcome significantly decreases.” If that is the case, then helpers in collaboration with their clients need to establish the kind of alliance that supports such change relatively quickly, if possible. DeFife and Hilsenroth (2011), in reviewing the evidence on effective therapeutic relationships identified three areas related to helping clients and therapists get off to a good start—positive expectations, a basic understanding of the helping process, and an emphasis on life-enhancing outcomes.

- Laura comes across as attentive, honest, and flexible. This helps Karl say to himself, perhaps subconsciously, “I think that I can work with her.”
- She shares the problem-management framework outlined in Chapter 2. She also gives her take on the PTSD framework, but humanizes it by tailoring it to Karl’s version of this syndrome.
- She helps Karl “normalize” his problems and concerns. Karl begins to see that, given what he has seen and gone through in both Iraq and Afghanistan, the problems that are plaguing him can be expected.
- Laura helps Karl understand the essential details of the helping process, including frequency of meetings, meeting length, work between sessions, and the like. But she adds, “Remember, you can ask any kind of question you want. If you have any objections, bring them up. If you think we are headed in the wrong direction, say so. What we are doing has to make sense to you.”
- She reinforces the notion that Karl is in the driver’s seat. She says, “I can help you see the options, but you will be making the decisions as we move along. My job is to help you design a better life. But you are in the driver’s seat.”

### **Keep the Client’s Points of View and Preferences Center Stage**

Bedi (2006) has suggested that the research community has given too much attention to therapists’ views of the helping relationship to the neglect of clients’ views. There are two key questions: First, what kind of relationship does the client want? Clients can differ widely in this regard. What does the therapist need to



do to help the client become a collaborating partner in the helping process? Duff and Bedi (2010) found that clients appreciate even “seemingly small, strengths-fostering behaviors such as making encouraging statements, making positive comments about the client, and greeting the client with a smile” can contribute, perhaps disproportionately, to alliance building. Bedi and Davis (2005) point out that helpers need to be trained in client-focused behaviors, especially in training programs that overstate the importance of treatment methods. In a word, stay in touch with what the client wants.

### **Approach the Relationship as a Forum for Relearning**

Even though helpers do not “cure” their clients, the relationship itself can be therapeutic. In the working alliance, the relationship itself is often a forum or a vehicle for social-emotional relearning (Mallinckrodt, 1996). Effective helpers model attitudes and behavior that help clients challenge and change their own attitudes and behavior. It is as if a client were to say to himself (though not in so many words), “She [the helper] obviously cares for and trusts me, so perhaps it is all right for me to care for and trust myself.” Or, “He takes the risk of challenging me. To tell the truth, I need to be challenged. So what’s so bad about challenge when it’s done well?” Or, “I came here frightened to death by relationships and now I’m experiencing a nonexploitative relationship that I cherish.” Furthermore, protected by the safety of the helping relationship, clients can experiment with different behaviors during the sessions themselves. The shy person can speak up, the reclusive person can open up, the aggressive person can back off, the overly sensitive person can ask to be challenged, and so forth.

Clients can then transfer what they are learning to other social settings. It is as if a client might say to herself, “He [the helper] listens to me so carefully and makes sure that he understands my point of view even when he thinks I should reconsider it. My relationships outside would be a lot different if I were to do the same.” Or, “I do a lot of stuff in the sessions that would make anyone angry. But she does not let herself become a victim of emotions, either her own or mine. And her self-control does not diminish her humanity at all. That would make a big difference in my life.” The relearning dynamic, however subtle or covert, is often powerful. In sum, needed changes in both attitudes, emotional expression, and behavior often take place within the sessions themselves through the relationship.

Finally, do not be discouraged if a fully collaborative relationship does not pop up immediately. Keep on doing the right things, but remember that what you think is most important may not be what the client thinks. At one point Karl says, “I keep thinking that I should see you as my mom or teacher or nurse or something and I’m a kid or a student or a patient. But I don’t really feel that way.” Laura replies, “So it’s taking a bit of time getting a fix on what this relationship is about.” Karl, “Yeah that’s it. This is something new for me. I’m not quite there yet.”

Breakdowns in client-helper relationships do happen, so it is essential to know how to get back on track. Eubanks-Carter, Muran, and Safran (2010) outline ways of dealing with challenges, misunderstandings, impasses, deterioration, stress, and threats to the relationship. They point out how these “ruptures,” as

they call them, can be transformed into opportunities for change and growth. People build relationships through conversations and behavior. This chapter outlines how we should behave toward clients. Part II outlines what successful conversations with clients look like. The communication and relationship building skills needed to handle ruptures are detailed in Part II.

### Reimagine Helpers and Clients as Entrepreneurs

The role of therapist can be considered somewhat narrowly, say as defined by the APA or the ACA, or widely, for instance, therapist as writer, actor, musician, and/or dancer (Farber, 2017). There are advantages (and some risks) in the latter approach. Chandra and Leong (2016) suggest that such “role-portfolio diversity” has distinct advantages: “A greater degree of role-portfolio diversification leads to (a) greater interpersonal efficacy and (b) social competency” (p. 860), two traits needed by therapists.

And so, we suggest adding a more innovative (some would say wilder) role for the therapist in the client-helper relationship—the counselor as entrepreneur helping clients discover the entrepreneur within themselves. Definition.com defines an entrepreneur as some who “organizes and manages any enterprise . . . with considerable initiative and risk.” Entrepreneurs are innovators. While the “enterprise” is usually considered to be some kind of business, this does not need to be the case. For instance, a social entrepreneur is someone who engages in entrepreneurial activity that benefits society (Bornstein, 2007; Bornstein & Davis, 2010; Martin & Osberg, 2015; MacMillan & Thompson, 2013; Shapiro, 2013). *The Skilled Helper* considers two kinds of enterprise—the helping process itself is one enterprise and the life of the client is another. Both can benefit from entrepreneurial activity, that is, both helper and client can engage in entrepreneurial activity that leads to successful helping in terms of life-enhancing client outcomes. Collaboration is a primary entrepreneurial value. Entrepreneurs, as innovators and agents of change, tend to be “gutsy.” In no particular order, they:

- Are agents, doers
- Are risk takers
- See opportunities in problems and crises
- Live by possibilities
- Know how to get things done both alone and with the help of others
- Are flexible
- Believe that everyone can be a change maker
- Are collaborators
- Attack issues with vision, action, and perseverance
- See the big picture but are not just dreamers
- Appreciate diversity
- Have a “growth” rather than a “fixed” mindset
- Have determination in face of adversity
- Ask unconventional questions
- Are cross disciplinary by nature
- Are willing to break free of established structures
- Know how to sell their ideas to others

- Build platforms that enable others to become change makers
- Help others envision new possibilities and appreciate their value
- Are at home with uncertainty
- Have a high need for autonomy, an “inner” source of control
- Prefer fixing to blaming
- Welcome rather than fear challenges
- Derive joy from and celebrate even small successes
- Change not just bad behavior but the systems that cause bad behavior
- Pursue outcomes that have impact
- Are effective in both identifying and dealing with the “enemies” of change—things such as apathy, bad habits in self and others, disbelief, incomprehension, vested interests, absurd demands, unforeseeable dangers, opposition, indifference, resource constraints, and so forth

The list could be longer, but what’s here gives you a feeling for the “entrepreneurial spirit.” Entrepreneurial behavior is intimately linked to the ‘design thinking’ approach to problem management outlined in Chapter 2.

The assumption here is that many clients and helpers have some degree of this entrepreneurial spirit however deeply buried or unused. Do you see pop culture as a therapeutic tool (Meyers, 2017)? Well, take a look.

But rather than view pop culture as the ruination of society, some counselors say that elements of popular entertainment can actually be used strategically to enhance client-counselor communication and the therapeutic relationship. These counselors—many of whom are enthusiastic consumers of “geek” culture themselves—are turning comic books, TV shows, movies, and video games into vital therapeutic tools. (p. 31)

This example of entrepreneurship in counseling may not be your cup of tea, but if it works, why not? Both helpers and clients would benefit by becoming more entrepreneurial—helpers in the enterprise called helping, counseling, or therapy, clients in the enterprise called life.

Let’s take a look at an example of an **entrepreneurial helper** helping a client discover and exploit the entrepreneur within herself.

Candace was counseling after a bitter divorce. She had a successful career in the financial industry. She was married to Adrian, an engineer who had a “decent job” in an aerospace company. They had no children and argued about the “right time” to have them. He wanted them “now,” while she said she needed more time to develop her career further. Adrian said that this was code for more money. Candace would shoot back with comments like, “Well, whatever it is, Mr. Better-Than-Thou, it would be better for the kids, better for all of us.” Their sex life was very run-of-the-mill. An angry Adrian once snidely told her that “the only real orgasm you have is on payday.” The collapsed marriage was followed by a bitterly contested divorce.

Candace thought the divorce would give her peace of mind and the freedom to pursue life in her own way. But she got neither. And so counseling was the next step. Bernie, a seasoned therapist with all the skills and values we have discussed so far, felt that those attempting to turn therapy into a strictly STEM science were “heading down a blind alley.” He incorporated what he saw as the best research had to offer into his practice but was steadfast in saying things like, “Come on, we are more than our neurons.” He was not just a therapist; he was also a social entrepreneur.

He found that each of his professions simulated thinking in the other. He saw that Candace was bright and a risk taker, at least in her career, so he felt that he could be more entrepreneurial than usual in his approach to her.

Here is one way in which his entrepreneurial approach was designed to elicit the entrepreneur within her. Helper self-disclosure (to be discussed in Part II) was part of this approach. He started by saying, “I need to understand better what makes you happy because success in your career doesn’t seem to do it. So let me tell you a little bit about myself.” He went on to talk briefly about his own financial situation. Like her he was single. Over the years he learned that financial success meant two things. First of all it meant saving enough for his old age because he wasn’t sure that anyone else was going to take care of him. Second, it took him too long to realize that money did not mean “more things” or some kind of undefined “high life.” Rather it meant freedom. He went on to describe what he meant by “freedom.”

Candace was startled, not so much by Bernie’s unexpected personal approach but by what he was describing. For her more money meant just that, more money. In finance that meant success. But, more important, she realized that Bernie had a “platform” that helped him understand and deal with money in his personal life. It was a platform that provided meaning. She created innovative platforms in finance but never thought of platforms that would give meaning to life. She told Bernie how surprised she was and went on, with Bernie’s help, to discuss what her preferred platform might be. A lot of her anxiety and depression centered on a lack of meaning in her life.

Note that one of the things that social entrepreneurs do is to help people challenge and renew the personal and social *systems* that act as guides for behavior. “To become a successful change maker . . . you need to understand the workings of the systems you hope to change and the history of the problem with which you are concerned” (Bornstein & Davis, 2010, p. 125). ). Bernie’s approach helped Candace challenge one of her life systems.

Finally, entrepreneurship, like design thinking, works best with a shared model or process of managing change. “A model is the framework or theory social entrepreneurs use to shape their work (Martin & Osberg, 2015). As such, the change model “serves as the scaffold for getting from undesirable to desirable” (p. 131). “Bridge,” “shape,” and “scaffold” are doing or making words; they have grit. The universal change framework described in Chapter 2 is at the heart of just about every scaffold.

## Determine the Key Values That Drive the Working Alliance **LO 3.2**

One of the best ways to characterize a helping relationship is through the values that permeate and drive it. The relationship is the vehicle through which values come alive. But the uncertainties associated with the beliefs-values-norms-ethics-morality package outlined in Chapter 1 cloud the issue.

The ethical codes adopted by the American Psychological Association, the American Counseling Association, the American Psychiatric Association, and other bodies in the helping professions provide a clear set of values and a detailed list of norms guiding the interactions between helpers and clients. These codes dissipate many of the uncertainties associated with the

beliefs-values-norms-ethics-morality package discussed in Chapter 1, but they do not eliminate them. Ethical uncertainties and conflicts will always bedevil the helping process. In this section we review the values that many people (including ourselves) believe “should” drive the helping process, but you will not find universal agreement on the “right” package. For instance, IDEO, whose model of change we received in Chapter 2, refers to its values as “mindsets.” The seven mindsets meant to drive behavior are empathy, optimism, iteration, creative confidence, making or doing, embracing ambiguity, and learning from failure (IDEO.org, 2015, pp. 17–25). In the end, you have to come up with a set of values that make sense to you and your clients and that keep you in compliance with both the ethical codes mentioned earlier and the laws of the land.

Borrowing from Argyris (1980; Argyris & Schön, 1974), values can be seen as “mental maps” which define how to act in situations. However, even though people have these behavioral maps, they do not always use them. So clients (like the rest of us) have both “espoused” values, which are like ideals, and “values-in-use,” that is, behavioral maps they use more or less consistently to make decisions and guide behavior. Often enough there is a split between espoused values and action on the part of either helper or client that adds a note of uncertainty to the helping process. Moreover, some values-in-use can lead to life-limiting rather than life-enhancing outcomes.

## See Values as Tools of the Trade

Values-in-use are not just mental states. They are tools that guide decision-making. They give rise to client-enabling helping behavior. A helper might say to himself during a session with a difficult client something like this:

This client needs to come to grips with her arrogant, I’m-always-right attitude. It distorts her decisions and poisons her relationships. It keeps her mired in her problems. How I give her feedback or, perhaps better, how I invite her to challenge herself is important. On the one hand, I do not want to damage our relationship; on the other, I value genuineness and openness. I do not want to belittle her, but I owe it to her to help her see herself as others see her. But I have to do this in the right way and at the right time. How can I help her “discover” this dimension of her behavior?

Values help counselors make decisions on how to proceed. Helpers without a set of working values are adrift. Those who don’t have an explicit set of values have an implicit or “default” set that may or may not serve the helping process. Therefore reviewing the values that drive your behaviors as a helper is not optional.

The power of values is dramatically illustrated in the value called conscientiousness (Bogg & Roberts, 2004; Friedman & Martin, 2011; Hill et al., 2011; B. W. Roberts, Walton, & Bogg, 2005). “*Conscientiousness* refers to individual differences in the propensity to follow socially prescribed norms for impulse control, to be task- and goal-oriented, to be planful, to delay gratification, and to follow norms and rules” (Bogg & Roberts, 2004, p. 887). While some would see this as a definition of a dull person, others would relate it to social-emotional intelligence and maturity. We do not know whether conscientiousness as a value is genetically and/or neurologically determined, whether it is the product of personal and social development, or whether it can be acquired and fostered through personal

choice and effort. But all the research shows that conscientious people live longer and healthier lives. Of course, there is an important question: Is conscientiousness genetic, environmental, or simply a choice? Probably some of each.

### **Determine the Values Inherent to Successful Helping**

Helping-related values, like your other values, cannot be handed to you on a platter. Much less can they be shoved down your throat. Therefore this chapter is meant to stimulate your thinking about the values that should drive helping. In the final analysis, as you sit with your clients, only those beliefs, values, and norms that you have made your own will make a difference in your helping behavior.

Of course, this does not mean that you will invent a set of values different from everyone else's. Tradition is an important part of value formation, and we all learn from the rich tradition of the helping professions. And so, in the following pages, four major values from the tradition of the helping professions—respect, empathy, an appreciation of diversity, and a bias toward action—are translated into a set of norms. Respect is the foundation value; empathy is the value that orients helpers to keep clients in the driver's seat; an appreciation of diversity is a value that opens you up to the world as it is; a bias toward action is an outcome-focused value. These values serve as a starting point for your reflection on the values that should drive the helping process. Don't just swallow them: Analyze, reflect on, and debate them. Come up with your own values package.

### **Prize Respect as the Foundation Value** LO 3.3

Respect for clients is the foundation on which all helping interventions are built. Respect is such a fundamental concept that, like most such concepts, it eludes definition. The word comes from a Latin root that includes the idea of “seeing” or “viewing.” Indeed, respect is a particular way of viewing oneself and others. If it is to make a difference, respect cannot remain just an attitude or a way of viewing others. Ideally, helpers and their clients “matter to one another” (Rayle, 2006). Carl Rogers (1957) early on saw the importance of respect calling it “positive regard” (p. 101) which includes nonpossessive warmth toward and affirmation of the client. Latter day research (Farber & Doolin, 2011) links these behaviors to successful client outcomes. Here are some norms that flow from the interaction between a belief in the dignity of the person and the value of respect.

#### **Avoid Behaviors Showing Disrespect**

Here are some things not to do lest you show disrespect to clients.

***Do no harm*** This is the first rule of the physician and the first rule of the helper (Lilienfeld, 2007; Rhule, 2005). Yet some helpers do harm either because they are unprincipled or because they are incompetent. Helping is not a neutral process—it is for better or for worse. In a world in which such things as child abuse, wife battering, and exploitation of workers are much more common than we care to think, it is important to emphasize a nonmanipulative and nonexploitative approach to clients.

***Do not rush to judgment*** You are not there to judge clients or to force your values on them. You are there to help them identify, explore, review, and challenge the consequences of the values they have adopted. Let us say that a client during the first session says somewhat arrogantly, “When I’m dealing with other people, I say whatever I want when I want. If others don’t like it, well, that’s their problem. My first obligation is to myself, being the person I am.” Irked by the client’s attitude, a helper might respond judgmentally by saying, “You’ve just put your finger on the core of your problem! How can you expect to get along with people with this kind of self-centered philosophy?” However, another counselor, taking a different approach, might respond, “So being yourself is one of your top priorities and being totally frank is, for you, part of that picture.” The first counselor rushes to judgment; the second neither judges nor condones. At this point she merely tries to understand the client’s point of view and let him know that she understands—even if she realizes that although the client would benefit from exploring the perhaps unintended consequences of such a philosophy, she believes that now is not the time to invite the client to self-challenge.

### **Engage in Behaviors Showing Respect**

These are the kinds of behavior through which you show respect to clients.

***Become competent and committed*** Master whatever model of helping you use. Get good at the basic problem-management and opportunity-development framework outlined in this book and the skills that make it work. There is no place for the “caring incompetent” in the helping professions. It would be great to say that everyone who graduates from some kind of helping training program is not only competent but also increases his or her competence over his or her career. Unfortunately, this is not the case.

***Be genuine*** Gelso (2011; Moore & Gelso, 2011) and others (Kolden et al., 2011) make a difference between the “real” relationship and the alliance described earlier. Gelso (2009a) has defined the real relationship as the “personal relationship existing between two or more people as reflected in the degree to which each is genuine with the other, and perceives and experiences the other in ways that befit the other” (pp. 254–255). That is, the relationship is real to the degree that it is empathic (explained later) and not phony. But there are various types of phoniness. If I pretend to like you but really do not, then I am being phony. The point is that phoniness is incompatible with respect. Another type of phoniness is to overstress your professional role. When I am with a client I am there as a helper, a catalyst, an encourager, a collaborator, and so forth. I am not there only as a member of my profession, an expert, the one with the answers, and so forth. The client’s success is my success. You are competent to the degree the client improves.

***Make it clear that you are “for” the client*** The way you act with clients will tell them a great deal about your attitude toward them. Your manner should indicate that you are “for” the client and that you care for him or her in a down-to-earth, nonsentimental way. It is as if you are saying to the client, “Working with



you is worth my time and energy.” Respect is both gracious and tough-minded. Being for the client is not the same as taking the client’s side or acting as the client’s advocate. “Being for” means taking clients’ points of view seriously even when they need to be challenged. Respect often involves helping clients place demands on themselves. Of course, this kind of “tough love” in no way excludes appropriate warmth toward clients.

**Assume the client’s goodwill** Work on the assumption that clients want to work at living more effectively, at least until that assumption is proved false. As we shall see later, the reluctance and resistance of some clients, particularly involuntary clients, is not necessarily evidence of ill will. Respect involves entering clients’ world to understand their reluctance and a willingness to help clients work through it.

**Keep the clients’ agenda in focus** Helpers should pursue their clients’ agendas, not their own. Here are three examples of helpers who lost clients because of lack of appreciation of their agendas. One helper recalled, painfully, that he lost a client because he had become too preoccupied with his theories of depression rather than the client’s painful depressive episodes. Another helper who dismissed as either trivial or irrelevant a client’s bereavement over a pet that had died was dumbfounded and crushed when the client made an attempt on her own life. The loss of the pet was the last straw in a life that was spiraling downward. A third helper, a white male counselor who prided himself on his multicultural focus in counseling, went for counseling himself when a Hispanic client quit therapy, saying, perhaps somewhat unfairly, as he was leaving, “I don’t think you’re interested in me. You’re more interested in Anglo-Hispanic politics.”

## Make Empathy the Primary Orientation Value **LO 3.4**

One critical way of showing respect is empathy, the ability to understand the client from his or her point of view and, when appropriate, to communicate this understanding to the client. Put simply, it involves an understanding of and feeling for the experiences, cognitions, behaviors, and emotions of another person and, I would add, how the person’s context influences all of these. The empathic person experiences the other in context. Although empathy is a rich concept in the helping professions, it has been a confusing one. The literature covering many different perspectives is overwhelming (Batson, 2011; Copland & Goldie, 2012; Decety, 2012; Elliott et al., 2010, 2011; Farrow & Woodruff, 2007; Gordon, 2007; Trout, 2009) with philosophers and psychologists, theoreticians and practitioners vying for our attention. Different theoreticians and researchers have defined it in different ways. Some see it as a personality trait, a disposition to feel what other people feel or to understand others “from the inside,” as it were. In this view some people are by nature more empathic than others. Others see empathy, not as a personality trait, but as a situation-specific state of feeling for and understanding of another person’s experiences. Still others, building on the specific state-of-feeling approach, have focused on empathy as a process with stages. For instance, Barrett-Lennard (1981) identified three phases—empathic

resonance, expressed empathy, and received empathy. Carl Rogers (1975) talked about sensing a client's inner world and communicating that sensing.

This book tries to simplify things for the helper. This chapter deals with empathy as a basic value that informs and drives all helping behavior. A chapter in Part II deals with empathy as a communication skill.

### **Consider This Brief Overview of Empathy as a Value**

All theoreticians, researchers, and practitioners agree on one thing: **Empathy** is important both in everyday life and in helping. Design thinking starts with empathy in the process of change: "In this [first] step you're learning what the issues are" (Roth, 2015, p. 12). "What's going on" and "What's really going on?" are important initial questions.

***Is empathy even possible?*** Can a helper really understand a client who is very different from him or her? This is a philosophical question. Can a normal person understand a person with bipolar disorder? Can a Hispanic male counselor understand a middle-class female Iranian-American client? The practical answer is yes (Hatcher et al., 2005). That is, helpers who espouse the value of empathy as outlined here and who have the communication competence described in Part II can help clients feel understood. Even better, empathy helps clients understand themselves more fully. As Ian McEwan says of a character in his 1990 novel *The Innocent*, "Now that he could name the fog he had been moving through, he was at last visible to himself."

***A rich concept*** A number of authors look at empathy from a value point of view and talk about the behaviors that flow from it. Sometimes their language is almost lyrical. For instance, Kohut (1978) said, "Empathy, the accepting, confirming, and understanding human echo evoked by the self, is a psychological nutrient without which human life, as we know and cherish it, could not be sustained" (p. 705). In this view, empathy is a value, a philosophy, or a cause with almost poetic overtones. Covey (1989), naming empathic communication as one of the "seven habits of highly effective people," said that empathy provides those with whom we are interacting with "psychological air" that helps them breathe more freely in their relationships. Goleman (1995, 1998, 2006) puts empathy at the heart of emotional intelligence. It is the individual's "social radar" through which he or she senses others' feelings and perspectives and takes an active interest in their concerns. As such, empathy lies at the heart of leadership (Goleman, 2006).

***The importance of empathy early in life*** The WAVE Trust, an international charity dedicated to advancing public awareness of the root causes of violence and the means to prevent and reduce it in society, commissioned research that came up with an extraordinary finding: "Empathy is the single greatest inhibitor of the development of propensity to violence. Empathy fails to develop when parents or prime caregivers fail to attune with their infants" (Hosking & Walsh, 2005, p. 20). In their research the definition of empathy is important. The researchers define empathy as what takes place when "the observed experiences of others come to affect our own thoughts and feelings in a caring fashion."

Empathy entails the ability to step outside oneself emotionally and to be able to suppress temporarily one's own perspective on events to take another's" (p. 20). To "attune" to a child means "attempting to respond to his or her needs, particularly emotionally, resulting in the child's sense of being understood, cared for, and valued" (p. 20).

Children should not only be the recipients of empathy, but also learn how to express empathy toward others. Kennedy (2008) argues for the importance of teaching children to be empathic toward others. Unless they both experience and express empathy, children are in danger of becoming self-centered, prone to aggressive and cruel behavior, and unable to feel or express remorse—a quasi-sociopathic interpersonal style. This happens when parents are unavailable physically and/or emotionally, when they are overindulgent, and when children are exposed to violent media. Kennedy urges parents to talk to their children about the emotions of others, model empathic communication and behavior, help children understand the need to make amends when they have harmed others, expose children to the less fortunate, allow children to feel useful forms of unhappiness such as frustration from not getting their way, and shield them from media with violent content.

### **See Empathy as a Two-Way Street**

Pedersen, Crethar, and Carlson (2008) show how helpers can increase their competence by moving beyond a traditional "this-individual-helper-trying-to-understand-this-individual-client" approach to empathy. Empathy at its best is relationship oriented. For instance, Zaki, Bolger, and Ochsner (2008) demonstrate that empathic accuracy depends on how both parties to a conversation communicate. Pedersen and his colleagues explore the many ways that cultural similarities and differences influence relationships in the counseling process and how important it is for helpers to become less focused on individuals and more focused on relationships.

Janet Clark (2003a, 2003b) has reconceptualized empathy in a similar way. Like Pedersen and his colleagues her definition of culture is very wide, including traits and characteristics that make individuals different from one another. She uses ethnographic concepts and principles (Goldstein, 1994; Green, 1995; Leigh, 1998) to focus on the individual client's unique frame of reference, rather than on a cultural group's frame of reference. She highlights some of the principal differences she sees between traditional one-way individualistic empathy and diversity-oriented two-way relationship empathy, what Pedersen and his colleagues call "inclusive cultural empathy."

### **Embrace Empathy as Radical Commitment**

Empathy as a value is a radical commitment on the part of helpers to understand clients as fully as possible in three different ways. First, empathy is a commitment to work at understanding each client from his or her point of view together with the feelings surrounding this point of view and to communicate this understanding whenever it is deemed helpful. Second, it is a commitment to understand individuals in and through the context of their lives. The social settings, both large and small, in which they have developed and currently "live and move

and have their being” provide routes to understanding. Third, empathy is also a commitment to understand the dissonance between the client’s point of view and reality. Understandably, providing feedback on this third type of empathy is a sensitive issue that will be discussed illustrated in detail in Part II. There is nothing passive about empathy. Empathic helpers respectfully communicate the kinds of understanding outlined in this paragraph to their clients and generally take an active interest in their concerns. Respectful empathy is very important when interacting with clients from different cultures and other forms of diversity (Wang et al., 2003). The communication of empathy is one of the best ways of helping clients remain in the driver’s seat.

If you want a bewildering view of every possible definition and explanation of empathy, go to [cultureofempathy.com](http://cultureofempathy.com). The overall message there is that empathy is a very important social value. An empathic society is a spiritually rich society. But don’t get lost in all of this. For helpers, empathy needs to be turned into a communication tool used to help clients manage problem situations and unused opportunities.

One final caution. A series of articles has appeared in the international press (Baggini, 2017; *Economist*, 2017; Held, 2017) dramatizing a definition and approach to empathy (Bloom, 2016a, 2016b) that has little or nothing to do with either the value or the communication skill of empathy defined, discussed, and illustrated in this book. Bloom (2016a) defines empathy as “the act of feeling what you believe other people feel—experiencing what they experience.” As you can see this is neither the value nor the communication skill that is central to helping. Bloom spells out the dangers he sees in his narrow definition and contrasts it to “rational compassion.” We make a point of this because of the “splash” his book has made and would not like to have people coming up to us saying, “I hear that someone has demolished that empathy stuff that you guys are always talking about.”

## Develop a Proactive Appreciation of Diversity as a Sense-of-the-World Value **LO 3.5**

Dealing knowledgeably and sensitively with diversity (Muran, 2006) and that particular form of diversity called culture requires respect and empathy. However, diversity is given special attention here because its importance in itself and because of positive and negative role it is playing across the world.

There has been such an explosion of literature on diversity and multiculturalism over the past few years that it is impossible to name the “must-read” books and articles. A simple search on the website of an Internet bookseller yielded over 16,000 entries. A dictionary of multicultural psychology (L. E. Hall, 2005) runs more than 170 pages. The word “fad” comes to mind. Fads take something that is very important (such as multiculturalism) and so overemphasizes it that it loses its importance. However, immersing yourself reasonably in this literature can force you to take a look at the blind spots they may have about diversity. Our education from primary through graduate school should help us develop what I call “a sense of the world,” but unfortunately very often this does not happen. Just review the 2016 presidential campaign. This despite the fact that understanding and

appreciating diversity has many advantages. For instance, there is evidence that “exposure to multiple cultures [and to all forms of diversity, I would add] in and of itself can enhance creativity” (Leung, Maddux, Galinsky, & Chiu, 2008, p. 169).

Failure to understand and appreciate diversity can have devastating consequences. Why? Putnam (2007) provides one answer. His research has shown that the more diverse a community, the less likely its inhabitants are to trust anyone, from the next-door neighbor to the town mayor. A similar but even more disturbing dynamic was discovered in a Swiss study. Participants were asked to fill out forms for a fictional study whereas they themselves were the subjects of the real study. As they entered the room, each of the participants was given a red or green pen together with a red or green name tag. They were told not to speak or interact with fellow participants as they filled out the forms. Later each participant sat with one of the researchers to discuss the forms. However, the researchers also asked about the experience of filling out the forms, the real focus of the research. This included questions about their observations of their fellow participants. To make a long story short, the researchers discovered that the “reds” did not much like the “greens” and the “greens” did not much like the “reds.” Thus a small *random* difference (color of pen and name tag) created some degree of animosity. Imagine what real differences can do!

You probably do not have to imagine. Just look around the world. Putnam (2007) goes on to point out that, in the long term, diversity can be enriching, but this does not happen automatically. Mere contact is not enough (see Dixon, Durrheim, & Tredoux, 2005). Often contact makes things worse. Communities and individuals need to work at it. This is a lesson our societies need to learn. There are many lessons to be learned from the 2016 United States presidential race. One is that polarization can rip a society apart.

### **Appreciate the Role of Culture, Personal Culture, and Values**

Because culture is the form of diversity that receives most of the attention, it is important to understand what the term means. Bronfenbrenner (1977) called it the “largest and most controlling of the systems” on both the individual and societal level. Once more, there are many different definitions of culture, but helpers need definitions that can be translated into practice. Values are central to culture, but culture is more than values. The fuller notion of culture is, briefly, this: *Shared beliefs and assumptions* interact with *shared values* and produce *shared norms* that drive *shared patterns of behavior*. Culture is usually not applied directly to individuals but rather to societies, institutions, companies, professions, groups, families, and the like. However, counselors do not deal immediately and directly with societies but individuals and small groups of individuals such as families. So if we apply this basic culture framework to an individual, it goes something like this:

- Over the course of life individuals develop *assumptions and beliefs* about themselves, other people, and the world around them. For instance, Isaiah, a client suffering from posttraumatic stress disorder stemming from gang activity in his neighborhood and a brutal attack he suffered, has come to believe that the world is a heartless place.

- In addition, *values*—what people prize—are picked up or inculcated along the path of life. Isaiah, because of dangers he encounters in his community, has come to value or prize personal security.
- Assumptions and beliefs, interacting with values, generate *norms of behavior*, the “dos” and don’ts” we carry around inside ourselves. For Isaiah one of these is, “Don’t trust people. You’ll get hurt.”
- These norms drive *patterns of internal and external behavior* and these patterns of behavior constitute, as it were, the bottom line of personal or individual culture—“the way I live my life.” For Isaiah this means being in a state of defensive alert whenever he is with people. It also means not taking chances with people. He tends to be a loner.

Because no individual is an island, personal cultures do not develop in a vacuum. The beliefs, values, and norms people develop are greatly influenced by the groups to which they belong. That said, individuals within any given culture can and often do personalize the beliefs, values, and norms of the cultures in which they live. People within the same culture tailor these beliefs, values, and norms in different ways (Massimini & Delle Fave, 2000). Individuals are not cultural carbon copies. Individuals from the same social culture often differ widely in their personal cultures. Effective helpers come to understand both the cultural background of their clients and the personal culture of each individual client. For instance, Isaiah has many of the cultural characteristics of his family, his ethnic group, his neighborhood, his school, and his socioeconomic class, but he is not a carbon copy of any of these cultures. His mix is unique.

Because patterns of behavior constitute the “bottom line” of culture, a popular definition of societal, institutional, and familial culture is “the way we do things here.” This definition applied to the individual client is “the way I choose to live my life.” Helpers, too, although influenced by the cultures of the various helping professions, have their personal cultures as helpers, that is, “the way I do helping.” Inevitably, the helper’s social-personal-professional culture interacts with the client’s for better or for worse.

The spirit of these principles needs to permeate the discussion of diversity and multiculturalism and its implications for helping practice as in the case of Sue Smith, a Midwestern American, who is married to Patrick Lee, an immigrant from Singapore. They come to a marriage counselor because they are having problems. Their helper, Antonio Ochoa, is a Hispanic-American whose parents immigrated to the United States. Many clients come to helpers because they are having difficulties in their relationships with others or because relationship difficulties are part of a larger problem situation. Therefore understanding clients’ different approaches to developing and sustaining relationships is important.

Guisinger and Blatt (1994) put this in a broader multicultural perspective: “Western psychologies have traditionally given greater importance to self-development than to interpersonal relatedness, stressing the development of autonomy, independence, and identity as central factors in the mature personality. In contrast, women, many minority groups, and non-Western societies have generally placed greater emphasis on issues of relatedness” (p. 104). In this case Sue is deep into the development of autonomy and her identity as



a successful working woman. Patrick runs a successful small website development business. Guisinger and Blatt go on to point out that both interpersonal relatedness and self-definition are essential for maturity. Helping Sue and Patrick, individuals from different cultures, achieve the right balance between the two depends on understanding what the “right balance” means in any given culture and what “right balance” means in their personal cultures. Antonio’s challenge is to put Clark’s principles into practice. When the values of different cultures clash (Knapp & VandeCreek, 2007), which set of values is to prevail? Multiculturalism solves some problems and raises others.

### **Acquire Competencies Related to Client Diversity and Culture**

Diversity competence refers to both the knowledge and the skills needed to relate, communicate effectively, and work with people with their own set of diversities (Constantine & Sue, 2008; Daniel, Roysircar, Abeles, & Boyd, 2004; Fraga, Atkinson, & Wampold, 2004; Worthington, Soth-McNett, & Moreno, 2007). Over the years people have drawn up a variety of lists outlining specific competencies (La Roche & Maxie, 2003) and hefty handbooks offering “the theoretical background, practical knowledge, and training strategies needed to achieve multicultural competence” (Pope-Davis, Coleman, Liu, & Toporek, 2004) have begun to appear. In addition, there are dozens—or by now hundreds—of highly detailed research studies offering further insights into multicultural competence (see Darcy, Lee, & Tracey, 2004). Day (2005, p. 31) notes that multicultural counseling competence “is usually conceptualized as including awareness of one’s own culture, biases, and values; knowledge about social and cultural influences on individuals; and skills for applying this knowledge in counseling.” But it seems that there is no universal agreement as to the “right” package of multicultural competencies (Kia ‘I Kitaoka, 2005).

The National Center for Cultural Competence at Georgetown University has adapted a cultural framework from a monograph developed by Cross and his colleagues (1989) for helpers. It is called the Cultural Competence Continuum and has six stages: cultural destructiveness, cultural incapacity, cultural blindness, cultural pre-competence, cultural competence, and cultural proficiency. Cultural competence includes “acceptance and respect for difference, continuing self-assessment, careful attention to the dynamics of difference, continuous expansion of knowledge and resources, and adaptation of services to better meet the needs of diverse populations.” I like the fact that they use the language of diversity rather than the narrower language of culture.

Here is my adaptation of a list of multicultural competencies outlined and illustrated by Hansen, Pepitone-Arreola-Rockwell, and Greene (2000). This is one of dozens of views on cultural competence and was chosen somewhat randomly. I have changed the language, separated what the authors have grouped, grouped what the authors had separated, introduced ideas from different authors, added thoughts of my own, and thereby introduced my own bias. My own bias, of course, is that diversity, especially diversity as represented in personal culture, is the key concept and that culture, important as it certainly is, is one among many key diversity factors. As a counselor, we must engage the personal culture of each client we see.



- Be aware of your own personal culture, including your cultural heritage, and how you might come across to people who differ from you culturally and in a host of other ways.
- Be aware of the personal-culture biases you may have toward individuals and groups other than your own.
- As a counselor, be aware of ways in which you are like any given individual and ways in which you differ. Both can aid or stand in the way of the helping process.
- Come to understand the values, beliefs, and worldviews of groups and individuals with whom you work.
- Come to understand how all kinds of diversity, cultural and otherwise, contribute to each client's dynamic makeup.
- Be aware of how sociopolitical influences such as poverty, oppression, stereotyping, stigmatization, discrimination, prejudice, and marginalization might have affected groups and individuals with whom you are working no matter what their culture might be. Culture is one among many targets of such abuse. Any sort of diversity—such as age, education, sexual orientation, and disability—can become targets of these negative behaviors.
- Realize that mainstream Western psychological theory, methods of inquiry, diagnostic categories, assessment procedures, and professional practices might not fit other cultures or might need some adaptation. Be aware that some of these factors might not even fit people from Western cultures that well because of within-culture diversity and other diversity factors beyond culture.
- Get to know the basics of family structure and gender roles of groups with whom you work. Remember that there can be great differences within any given culture. Culture does not automatically mean homogeneity.
- Develop an understanding of how people in different cultures understand and deal with illness, including mental illness, and how they feel about help-seeking behavior. Remember also that people in the same culture have wide differences in this regard because of their personal cultures.
- Establish rapport with and convey empathy to clients in culturally sensitive ways. Extend this sensitivity to the personal cultures of all clients. Be especially careful not to think that people from your own culture are all alike. You are establishing rapport and expressing empathy to individuals, not cultures or other forms of diversity.
- Recognize and appreciate cultural and personal-culture differences in interaction styles and language differences, including nonverbal communication, between yourself and your clients. Remember that people in the same culture communicate and interact in a whole range of ways.
- When clients tell their stories, recognize which issues are culture-specific and which are more related to universal human experience. If a young person is having some problems with his parents, realize that having problems with parents is close to a universal experience. In the words of a Jacques Brel song, "Who is the child without complaint?" Parents are not perfect. On the other hand, since parent-child relations differ widely from culture to culture, the specific twists of the problem are often culturally conditioned. But within-culture differences can also play a big role here.

- In cooperation with clients design non-biased treatment interventions and action plans that factor in key cultural and personal-culture variables.
- Initiate and explore issues of difference between yourself and your clients when this is appropriate. Remember that culture is only one difference. In the end, your interactions with your clients are a personal-culture to personal-culture affair.
- Assess your own level of cross-cultural and personal-culture competence and strive to improve in all the areas outlined above.
- Develop and practice what has been called “**cultural humility**” (Hook, Davis, Owen, & DeBlaere, 2017; Shaw, January, 2017). Helpers need to recognize their cultural limitations, which include making mistakes. For instance, counselors sometimes inadvertently use “cultural microaggressions” (Spengler, Miller, & Spengler, 2016) during their interactions with clients. Culturally humble helpers make fewer mistakes and when they do, tend to recognize and correct them.

In summary, work with your clients the way they are, but do not feel the need to apologize for who you are. Keep it simple. If we add up all the principles relating to cultural competence found in the psychological literature, we begin to get dizzy. Collins, Arthur, and Wong-Wylie (2010) outline 13 steps involving over 60 questions in a “cultural audit” to be used by practitioners. To me this is a step too far.

Stuart (2004), noting that it “is easy to endorse the principle of culturally sensitive practice, it is often much harder to make it a reality” (p. 3), has written an excellent article on ways of avoiding either overvaluing or undervaluing key cultural-competence behaviors in encounters with clients. When it comes to culture, complexity is the name of the game. He notes that no one is the repository of a “pure” culture.

Everyone belongs to multiple groups—nation, region, gender, religion, age cohort, and occupation to name a few—each of which exerts a different cultural influence that may be congruent, complementary, or in conflict with any of the others. Every influence is interpreted by each person, who decides whether and, if so, how personal beliefs should respond to each of these influences. Therefore every individual is a unique blend of many influences. Whereas culture helps to regulate social life, specific beliefs are products of individuals’ minds. Because of this complexity, it is *never* safe to infer a person’s cultural orientation from knowledge of any group to which he or she is believed to belong.

## Develop a Bias toward Action as an Outcome-Focused Value **LO 3.6**

If life-enhancing outcomes are central to helping, then the behavior that leads to these outcomes is also central. In the end, clients must engage, directly or indirectly, in the kind of internal (thinking) and external (action) behavior that creates these outcomes. The overall goal of helping clients become more effective in problem management and opportunity development was mentioned in Chapter 1. That means helping them become more effective “agents” in the

helping process and in their daily lives—doers rather than mere reactors, preventers rather than fixers, initiators rather than followers.

Lawrence was liked by his superiors for two reasons. First, he was competent—he got things done. Second, he did whatever they wanted him to do. They moved him from job to job when it suited them. He never complained. However, as he matured and began to think more of his future, he realized that there was a great deal of truth in the adage, “If you’re not in charge of your own career, no one is.” After a session with a career counselor, he outlined the kind of career he wanted and presented it to his superiors. He pointed out to them how this would serve both the company’s interests and his own. At first they were taken aback by Lawrence’s assertiveness, but then they agreed. Later, when they seemed to be sidetracking him, he stood up for his rights. Assertiveness was his bias for action.

One of the fundamental values or “mindsets” in the design-thinking approach to problem management outlined in Chapter 2 is “make it.” Problem managers are “doers, tinkerers, crafters, and builders. . . . We have a bias toward action, and that means getting ideas out of our heads and into the hands of the people we’re looking to serve” (IDEO.org, 2015, p. 20). *The Skilled Helper* has emphasized this bias toward action for over 40 years, urging counselors and therapists to help clients discover the “doer” within themselves. As the graphic of problem management (Chapter 2) indicates, client action should start right at the beginning of the helping process and continue until desired outcomes with desired impact are achieved. For a bias toward action to become a value-in-use rather than remain a merely espoused value it is necessary to consider both action expectations and the information and skills needed to act. First we look at client expectations through the lens of “self-efficacy” (Bandura, 1986, 1989, 1991, 1995, 1997, 2001, 2006; Cervone, 2000; Cervone & Scott, 1995; Lightsey, 1996; Locke & Latham, 1990; Maddux, 1995; Schwarzer, 1992).

### Understand the Nature of Self-Efficacy

As Bandura (1995, p. 2) notes, “Perceived self-efficacy refers to beliefs in one’s capabilities to organize and execute the courses of action required to manage prospective situations. Efficacy beliefs influence how people think, feel, motivate themselves, and act.” People’s expectations of themselves and can-do beliefs have a great deal to do with their willingness to put forth effort to cope with difficulties, the amount of effort they will expend, and their persistence in the face of obstacles. Clients tend to take action when two conditions are fulfilled:

1. **Outcome expectations** Clients tend to act when they see that their actions will most likely lead to certain life-enhancing accomplishments. Nicolas is talking to a friend about his troubled relationship with his wife and mother-in-law. Political differences separate them. Nicolas believes that everything would be better if they were to talk about values rather than politics. He is not openly religious any more (they are), but the values at the heart of religion still motivate him. He has been hesitant to talk about these values because he knows that he does not always live up to them. He also made the mistake of thinking that talking about values

is the same as talking about religion. Taking about his values and about his failure to live up to them at times would lead to a different kind of conversation and a different kind of relationship. “If I put the cards on the table in a decent way, I will have better conversations with both Andrea and her mother and a more honest and stable relationship with both of them. What started with the presidential campaign continues to this day and has brought out the worst in all of us. I don’t want that to continue.”

2. **Self-efficacy beliefs** People tend to act when they are reasonably sure that they have the wherewithal—for instance, working knowledge, skills, time, stamina, guts, and other resources—to successfully engage in the kind of behavior that will lead to the desired outcomes. Nicholas continues: “Up to now I haven’t had the guts to put my cards on the table. I was ashamed to do so. But I talked this through with a counselor last week—even rehearsed some of it—so I know I can do it. Right now I have the courage to do it, so all I can say now is ‘watch me!’ They might not react the way I want them to right away, but that’s OK. I can handle it.”

Now let’s see these two factors operating together in a few examples.

Yolanda, who has had a stroke, not only believes that participation in a rather painful and demanding physical rehabilitation program will literally help her get on her feet again (an outcome expectation), but she also believes that she has what it takes to inch her way through the program (a self-efficacy belief). She therefore enters the program with a very positive attitude and makes good progress.

Yves, on the other hand, is not convinced that an aggressive drug rehabilitation program will lead to a more fulfilling life (a negative outcome expectation), even though he knows he could “get through” the program (a self-efficacy belief). So he says no to the therapist’s suggestion that he enter the program. Yves keeps saying to himself, “Drug-free for what?” He realizes that being drug-free is not a goal with the kind of life-enhancing impact he needs. But he has not yet come up with an attractive ultimate goal. He needs something to live for.

Xavier is convinced that a series of radiation and chemotherapy treatments would help him (a positive outcome expectation), but he does not feel that he has the stamina and courage to go through with them (a negative self-efficacy expectation). He, too, refuses the treatment.

Expectations, while necessary, are not sufficient. These expectations must lead with some consistency to life-enhancing action. How can we help clients take on the kind of self-responsibility that moves them to action?

### **Promote Self-Responsibility by Helping Clients Develop and Use Self-Efficacy**

Helpers do not self-righteously “empower” clients. That would be patronizing and condescending. In a classic work, Freire (1970) warned helpers against making helping itself just one more form of oppression for those who are already oppressed. Effective counselors help clients discover, develop, and use the untapped power within themselves and use these resources to get things done. Here, then, is a range of empowerment-based norms, some adapted from the work of Farrelly and Brandsma (1974).

***Start with the premise that clients can change if they choose*** Clients have more resources for managing problems in living and developing opportunities than they—or sometimes their helpers—assume. The helper's basic attitude should be that clients have the resources both to participate collaboratively in the helping process and to manage their lives more effectively. These resources may be blocked in a variety of ways or simply unused. The counselor's job is to help clients identify, free, and cultivate these resources. The counselor also helps clients assess their resources realistically so that their aspirations do not outstrip their resources.

***Do not see clients as victims*** Even when clients have been victimized by institutions or individuals, don't see them as helpless victims. The cult of victimhood is already growing too fast in society. Even if victimizing circumstances have diminished a client's degree of freedom—the abused spouse's inability to leave a deadly relationship, for example—work with the freedom that is left.

***Do not see clients as overly fragile*** Neither pampering nor brutalizing clients serve their best interests. However, many clients are less fragile than helpers make them out to be. Helpers who constantly see clients as fragile may well be acting in a self-protective way. Driscoll (1984) noted that early in the helping process, too many helpers shy away from doing much more than listening. The natural deference many clients display early in the helping process (Rennie, 1994)—including their fear of criticizing the therapist, understanding the therapist's frame of reference, meeting the perceived expectations of the therapist, and showing indebtedness to the therapist—can send the wrong message to helpers.

***Do not be fooled by appearances*** One supervisor in a meeting with his colleagues dismissed a reserved, self-deprecating trainee with the words, "She'll never make it. She's more like a client than a trainee." Fortunately, his colleagues did not work from the same assumption. The woman went on to become one of the program's best students. She was accepted as an intern at a prestigious mental-health center and was hired by the center after graduation. Her supervisor failed to develop an empathic understanding of the trainee. Angus and Kagan (2007) link empathy and action. They say that when helpers respond with empathy to clients who talk about what they have done to bring about positive change in their lives, they encourage clients' sense of personal agency. The trainee developed a sense of agency on her own.

***Help clients see counseling sessions as work sessions*** Helping is about client-enhancing change. Therefore counseling sessions deal with exploring the need for change, determining the kind of change needed, creating programs of constructive change, engaging in change "pilot projects," and finding ways of dealing with obstacles to change. This is work, pure and simple. This search for and implementation of solutions can be arduous, even agonizing, but it can also be deeply satisfying, even exhilarating. Helping clients develop the "work ethic" that makes them partners in the helping process can be one of the helper's most

formidable challenges. Some helpers go so far as to cancel counseling sessions until the client is “ready to work.” Helping clients discover incentives to work is hard work in itself.

***Become a coach or consultant to clients*** Helpers can see themselves as coaches or “expert consultants” (Mee-Lee, McLellan, & Miller, 2010, p. 403) engaged by clients (or third parties) to help them face problems in living more effectively. This is a design-thinking approach to counseling. Coaches and consultants in the business world adopt a variety of roles. They listen, observe, collect data, report observations, teach, train, provide support, challenge, advise, offer suggestions, and even become advocates for certain positions. But the responsibility for running the business remains with those who hire the consultant. Therefore even though some of the activities of the coaches or consultant can be seen as quite challenging, the decisions are still made by managers. Coaching and consulting, then, are **social-influence processes**, but collaborative ones that do not rob managers of the responsibilities that belong to them. In this respect, it is a useful analogy to helping. The best clients, like the best managers, learn how to use their coaches or consultants to add value in managing problems and developing opportunities.

***Focus on learning and doing instead of helping*** Although many see helping as an education process, it is probably better characterized as a learning process. Effective counseling helps clients get on a learning track. Both the helping sessions themselves and the time between sessions involve learning, unlearning, and relearning. Howell (1982) gave us a good description of learning when he said that “learning is incorporated into living to the extent that viable options are increased” (p. 14). In the helping process, learning takes place when options that add value to life are opened up, seized, and acted on. If the collaboration between helpers and clients is successful, clients learn in very practical ways. They have more “degrees of freedom” in their lives as they open up options and take advantage of them.

***Be aware of cultural differences*** There are cultural differences in the ways people approach self-responsibility and agency. Some clients are reluctant to act, while others are too willing. Consider research done with some Taiwanese university students. They tended to see help seeking as a sign of weakness, even as a cause for shame; informal was more acceptable than formal help; the situation had to be quite serious before they would think of seeking help; and they were reluctant to seek help from strangers (Lin, 2002). When one trainer played the role of a client with a student from Sri Lanka, the student could hardly speak. When asked what the problem was, he said that teachers in his culture were authority figures to be respected. “How could a teacher be a client?” he asked.

### **An Amazing Case of Client-Initiated Action**

As indicated earlier, many, if not most, client problems are managed or coped with, not solved. Consider the following, very real case of a woman who certainly did not choose not to change. Quite the contrary. Her case is an amazing



example of a no-formula approach to developing and implementing a program for constructive change.

Vicky readily admits that she has never fully “conquered” her illness. Some 20 years ago, she was diagnosed with manic-depressive disorder (now called “bipolar disorder”). The picture looked something like this: She would spend about six weeks on a high; then the crash would come, and for about six weeks she would be in the pits. After that she would be normal for about eight weeks. This cycle meant many trips to the hospital. Some seven years into her illness, during a period in which she was in and out of the hospital, she made a decision. “I’m not going back into the hospital again. I will so manage my life that hospitalization will never be necessary.” This nonnegotiable goal was her manifesto.

Starting with this declaration of intent, Vicky moved on, in terms of Task B of Stage II, to spell out what she wanted: (1) She would find ways to channel the energy of her “highs”; (2) she would consistently manage or at least endure the depression and agony of her “lows”; (3) she would not disrupt the lives of others by her behavior; (4) she would not make important decisions when either high or low. Vicky, with some help from a rather nontraditional counselor, began to do things to turn those goals into reality. She used these broad goals to provide direction for everything she did.

Vicky learned as much as she could about her illness, including cues about crisis times and how to deal with both highs and lows. To manage her highs, she learned to channel her excess energy into useful—or at least nondestructive—activity. Some of her strategies for controlling her highs centered on the phone. She knew instinctively that controlling her illness meant not just managing problems but also developing opportunities. During her free time, she would spend long hours on the phone with a host of friends, being careful not to overburden any one person. Phone marathons became part of her lifestyle. She made the point that a big phone bill was infinitely better than a stay in the hospital. She called the phone her “safety valve.” She went so far as to set up her own phone-answering business and worked very hard to make it a success.

She would also do whatever she had to do to tire herself out and get some sleep, for she had learned that sleep was essential if she was to stay out of the hospital. This included working longer shifts at the business. She made exercise an important part of her daily routine. She developed a cadre of supportive people, including her husband. She took special care not to overburden him. She made occasional use of a drop-in crisis center but preferred avoiding any course of action that reminded her of the hospital.

It must be noted that the central driving force in this case was Vicky’s decision to stay out of the hospital. Her determination drove everything else. Urgency became central to Vicky’s life. Her case exemplifies the spirit of action that ideally characterizes the implementation stage of the helping process. Here is a woman who, with occasional help from a counselor, took charge of her life and turned her bipolar disorder into an asset. She set some simple goals and devised a set of simple strategies for accomplishing them. She never looked back. And she was never hospitalized again. Some will say that she was not “cured” by this process. But her goal was not to be cured but to lead as normal a life as possible. Some would say that her approach lacked elegance. Perhaps, but it certainly did not lack results. She seized life.



## **Influence Clients to Embrace Self-Responsibility** **LO 3.7**

The title of this section might seem odd to some. If counselors influence their clients, don't they rob them of some of their self-responsibility? What follows should lead to a "no" answer.

Robert Zoellick (2009), a former president of the World Bank, in reviewing the problems the world faces at the beginning of a new century, muses on how the first half of the 21st century should be defined. He dismisses such terms as the Age of Reversal, the Age of Intolerance, and the Age of Decline. Rather he opts for a more upbeat term—the Age of Responsibility. The value of self-responsibility assumes that the client has the power to do what is right for self and others. The second and third goals of helping outlined in Chapter 1—helping clients develop a problem-management and opportunity-development approach to life and a preference for prevention rather than cure—are both empowerment skills. However, helpers do not empower clients. Rather they help clients discover, acquire, develop, and use the power they have at the service of constructive life change—that is, they help clients identify, develop, and use resources that will make them more effective agents of change both within the helping sessions themselves and in their everyday lives (Strong, Yoder, & Corcoran, 1995). The opposite of empowerment is dependency (Abramson, Cloud, Kesse, & Kesse, 1994; Bornstein & Bowen, 1995), deference (Rennie, 1994), and oppression (McWhirter, 1996). Because helpers are often experienced by clients as relatively powerful people and because even the most egalitarian and client-centered of helpers do influence clients, it is necessary to come to terms with social influence in the helping process.

### **Realize That Helping Is a Social-Influence Process**

People influence one another every day in every social setting of life. E. R. Smith and Mackie (2000) consider it one of eight basic principles needed to understand human behavior. William Crano (2000) suggests that "social influence research has been, and remains, the defining hallmark of social psychology" (p. 68). Parents influence each other and their kids. In turn they are influenced by their kids. Teachers influence students and students influence teachers. Bosses influence subordinates and vice versa. Team leaders influence team members, and members influence both one another and the leader. The world is abuzz with social influence. It could not be otherwise. Rashotte (2006) makes a difference between social influence and power plays:

Social influence is defined as change in an individual's thoughts, feelings, attitudes, or behaviors that results from interaction with another individual or a group. Social influence is distinct from conformity, power, and authority. . . . Social influence, however, is the process by which individuals make real changes to their feelings and behaviors as a result of interaction with others who are perceived to be similar, desirable, or expert. (p. 4426)

Clients tend to dislike social influence they see as a form of power because power too often leads to manipulation and oppression (McCarthy & Frieze, 2002).

Years ago Strong (1968) wrote an article entitled “Counseling: An interpersonal influence process” that proved to be very influential. From then on helping as a social-influence process received a fair amount of attention in the helping research literature, a lot of it stemming from Strong’s original article (Dorn, 1986; Heppner & Claiborn, 1989; Heppner & Frazier, 1992; Houser, Feldman, Williams, & Fierstien, 1998; W. T. Hoyt, 1996; McCarthy & Frieze, 1999; McNeill & Stolenberg, 1989; Strong, 1991; Tracey, 1991). In 1980 Corrigan and his associates did an extensive review of the research. They opened by saying that “virtually all human relationships involve persons attempting to influence each other” (p. 395). Forty pages later they end with the curt conclusion that “counselors are influential.” But how? And to what purpose? In a more recent review of social influence in therapy Perrin and his colleagues (2010) suggest that the, relatively speaking, more recent emphasis on diversity and multiculturalism has done much to reduce helpers’ tendency to overly influence their clients and has created a new perspective “in which the top-down aspect of social influence by therapists towards clients is deemphasized and a more interactive, reciprocal, and collegial influence process is given renewed emphasis” (p. 451).

The skimpy research tells us what we probably already know. Social influence is pervasive in human interactions and, understandably, it pervades the helping professions. The point here is that helpers can influence clients without robbing them of self-responsibility. Even better, they can exercise their trade in such a way that clients are, to use a bit of current business jargon, “empowered” rather than oppressed both in the helping sessions themselves and in the social settings of everyday life. There is a growing and quite diverse literature and debate on the role of social justice in the helping professions (Daniels & D’Andrea, 2007; Goodman, 2009; Jencius, 2010; Kenny, Horne, Orpinas, & Reese, 2009; King, 2011; C. C. Lee, 2007; Ratts, Toporek, & Lewis, 2010; Shallcross, 2010; Smith, Reynolds, & Rovnak, 2009). One of the themes in this literature is the potential power imbalance in helping relationships with the helper being “one up,” although this supposition, too, has been challenged (Zur, 2008). At any rate, the properly “empowered” client, that is, a client whose resources for **self-regulation** and improvement are recognized and appreciated, faces another challenge—the exercise of self-responsibility.

Imagine a continuum. At one end lies “directing clients’ lives” and at the other “leaving clients completely to their own devices.” Thaler and Sunstein (2008) suggest that the latter is impossible. “In many situations, some . . . agent *must* make a choice that will affect the behavior of other people. There is, in those situations, no way of avoiding nudging in some direction, and whether intended or not, these nudges will affect what people choose” (p. 10). Helping is one of those situations. Somewhere along that continuum is “helping clients make their own decisions and act on them.” Most forms of helper influence will fall somewhere in between the extremes. Preventing a client from jumping off a bridge moves, understandably, to the controlling end of the continuum. On the other hand, simply accepting and in no way challenging a client’s decision to put off dealing with a troubled relationship because he or she is “not ready” moves toward the other end. As Hare-Mustin and Marecek (1986)

noted, there is a tension between the right of clients to determine their own way of managing their lives and the therapist's obligation to help them live more effectively.

### **Accept Helping as a Natural, Two-Way Influence Process**

Helping is a two-way street. Tyler, Pargament, and Gatz (1983), seeing both helper and client as people with defects, focused on the give-and-take that should characterize the helping process. In their view, either client or helper can approach the other to originate the helping process. The two have equal status in defining the terms of the relationship, in originating actions within it, and in evaluating both outcomes and the relationship itself. In the best case, positive change occurs in both parties.

Clients and therapists change one another in the helping process. Even a cursory glance at helping reveals that clients can affect helpers in many ways. For instance, Wei-Lian has to correct Timothy, his counselor, a number of times when Timothy tries to share his understanding of what Wei-Lian has said. For instance, at one point, when Timothy says, "So you don't like the way your father forces his opinions on you," Wei-Lian replies, "No, my father is my father and I must always respect him. I need to listen to his wisdom." The problem is that Timothy has been inadvertently basing some of his responses on his own cultural assumptions rather than on Wei-Lian's. When Timothy finally realizes what he is doing, he says to Wei-Lian, "When I talk with you, I need to be more of a learner. I'm coming to realize that Chinese culture is quite different from mine. I need your help."



# The Therapeutic Dialogue: Master Communication and Relationship- Building Skills

**G**iven the importance of the therapeutic relationship and alliance highlighted in Chapters 1 and 3, the communication and relationship-building skills that helpers need to engage in the behaviors outlined in Chapter 3 are described and illustrated in Part II. These skills are among the key ingredients of successful helping and are what makes the “engine” of the problem-management framework go as introduced in Chapter 2. Moreover, therapists with good communication skills can help clients who have lower levels of these skills engage more collaboratively and effectively in the helping process.

Chapter 4 highlights and illustrates the importance of the therapeutic dialogue together with the skills of *tuning in*, *attending*, and *active listening*.

Chapter 5 deals with *empathy* as a communication skill.

Chapter 6 outlines and illustrates how *probing* and *summarizing* can help clients engage more fully in the helping process.

Chapter 7 considers the role of *challenge* and *client-self challenge* in therapy. The importance of helping clients move beyond blind spots and develop *new perspectives* that serve life-enhancing outcomes is highlighted.



# Therapeutic Presence: Tune In to Clients and Listen Carefully

## LEARNING OBJECTIVES

### 4.1 Become Competent in the Communication Skills Needed in Helping

### 4.2 Make Dialogue Second Nature to Your Interactions with Clients

### 4.3 Demonstrate Empathic Presence by Visibly Tuning In to Clients

- Adopt Basic Guidelines for Visibly Tuning In to Clients

- Use Nonverbal Behavior as a Channel of Communication

- Learn to Read the Signals That Both You and Your Clients Are Sending

### 4.4 Make Active Listening the Foundation of Understanding

- Avoid Forms of Poor Listening

- Listen Carefully to Clients' Stories in Terms of Experiences, Thoughts, Behaviors, and Feelings

- Put It All Together by Listening to the Client's Integrated Narrative

- Process What You Hear in a Thoughtful Search for Meaning

- Listen to Your Own Internal Conversation

### 4.5 Listen to the Key Ingredients of Successful Therapy

- Listen to the Client

- Listen to Your Own Thoughts, Feelings, and Behaviors

- Listen to What's Happening in the Relationship

- Listen to the Flow of Communication Skills and Dialogue

- Listen to the Two-Way Feedback Process between You and Your Clients

- Listen to the Decisions Being Made

- Listen to the Key Assumptions, Beliefs, Values, Norms, and Ethical Issues in Play

- Listen to the Problem-Management Process Embedded in Whatever Treatment Model You Use.

### 4.6 Identify and Deal with All Forms of Distorted Listening



## Become Competent in the Communication Skills Needed in Helping LO 4.1

Although there is a great deal of research on the importance of the helping relationship and a variety of suggestions on how to develop and maintain a solid helping relationship, the research literature says little about the communication and relationship-building skills needed to do this. Perhaps this is related to the taken-for-granted attitude toward effective communication in many societies, including our own. **Communication skills** are viewed unequivocally as foundational. A quick Internet search on communication skills yields a deluge of websites with articles belaboring the importance and centrality of such skills to success in business, work relationship, social and family relationships, and, well, life. Yet, as a society, we have pretty much left them to chance. We generally hope they are picked up along the way, often ascribing interpersonal and social skills as an inherent attribute rather than something that can be learned. Although such skills may come more naturally for some, we believe that such skills can be developed and improved upon. Some disciplines are beginning to recognize that such skills cannot be left to chance. For example, many medical schools now incorporate communication skill training into their curriculum, with what are often called “**patient-centered skills**” (Levinson, Lesser, & Epstein, 2010). Medicine has learned that working collaboratively with patients is critical to promoting motivation, treatment adherence, and better patient outcomes (Bennett et al., 2009; Kelly et al., 2014). Basic communication skills are an essential part of this process.

And so communication skills on the part of helpers are a key ingredient to successful helping. However, the communication skills outlined in these chapters are not special skills peculiar to helping. Rather, they are extensions of the kinds of skills all of us need in our everyday interpersonal transactions (Adler, Proctor & Towne 2007; Canary, Cody, & Manusov, 2008; DeVito, 2011, 2012, 2013; West & Turner, 2011; Wood, 2009). Ideally, helpers-to-be would enter training programs with this basic set of interpersonal communication skills in place, and training would simply help them adapt the skills to the helping process. Unfortunately, this is often not the case. Training or retraining in communication skills is the norm when it comes to “therapeutic communication” (Knapp, 2007). These communication skills need to become “**second nature**” to helpers. People like Carl Rogers (1951, 1957, 1965), Bob Carkhuff (1987), and Allen Ivey (Ivey, Ivey, & Zalaquett, 2016), to name a few, have been trailblazers in developing and humanizing communication skills and integrating them into advances in the helping process. Their influence is seen throughout this book.

The chapters in Part II outline and illustrate the following skills—attending (empathic presence), listening, understanding what clients are thinking and saying about themselves, responding to clients with understanding, helping clients explore their concerns more fully, helping them to stay focused, and helping clients challenge themselves to develop new perspectives on their problem situations and unused opportunities. The manual (Egan & Reese, 2018) that accompanies this text, *Exercises in Helping Skills*, provides opportunities for extensive practice in all the communication skills discussed in these chapters.

It would be helpful if clients had the communication skills outlined here and the ability to weave them into constructive dialogues with their helpers. Once more, this is often not the case. In fact, many clients are in trouble precisely because they do not know how to establish and maintain healthy interpersonal relationships which are nourished by effective communication. In the following chapters, you will find suggestions for helping clients with poor communication skills engage in dialogue.

## Make Dialogue Second Nature to Your Interactions with Clients

LO 4.2

Interpersonal communication competence means not only being good at the individual communication skills outlined in this and the following chapters, but also marshaling them at the service of dialogue (Pare´ & Lysack, 2004; Seikkula & Trimble, 2005). There are four requirements for true dialogue (Egan, 2012):

**1. Turn Taking.** Dialogue is interactive. You talk, then the other person talks. In counseling this means that, generally speaking, monologues on the part of either client or helper don't add value. Endless stories on the part of clients and equally endless lectures on the part of helpers have no place in counseling. Monologues breed isolation. Dialogue demands engagement. Turn taking opens up the possibility for mutual learning. Helpers learn about their clients and base their interventions on what they come to understand through the give-and-take of the dialogue. Clients come to understand themselves and their concerns more fully and learn how to face up to their problems and unused opportunities.

**2. Connecting.** Have you ever witnessed (or engaged in) a conversation when the two parties keep talking past each other? Alternating monologues have no place in therapy. Ideally, what either client or helper says in the conversation should be connected in some way to what the other has said. The helper's responses should connect to the client's remarks and, ideally, clients should connect with what their helpers are saying. That is, helper and client need to engage each other if their working alliance is to be productive. They need to actively listen to one another and respond in terms of what they think the other person is saying. Later in Part II we discuss what you can do to help clients who are not up to speed in their ability to connect.

**3. Mutual Influencing.** In true dialogue the parties are open to being influenced by what the other person has to say. This echoes the social-influence dimension of counseling discussed in Chapter 3. Helpers influence their clients, and open-minded helpers learn from and are influenced by their clients. In fact, it is impossible for clients to remain in the driver's seat without influencing their helpers. In very real ways clients and helpers continually challenge one another to be open to new learning. Fowers and Davidov (2006, 2007) suggest that the virtue of "openness to the other" and dialogue can foster and facilitate dialogue with people who have different backgrounds, including race, ethnicity, gender, religion, age, and/or other differences. Openness starts with trying to understand what the client's thoughts, feelings, and behaviors mean to the client. Dialogue

offers the opportunity to further this understanding and to create shared understanding. The pairing of the two keeps both client and helper on track.

**4. Co-creating Outcomes.** Good dialogue leads to outcomes that benefit both parties. As we have seen, counseling is about results, accomplishments, and outcomes. The job of the counselor is neither to tell clients what to do nor merely to leave them to their own devices. The counselor's job is to act as a catalyst for the kind of problem-managing dialogue that helps clients find their own answers. In true dialogue, neither party should know exactly what the outcome will be. If you know what you're going to tell a client or if the client has already made up his or her mind what he or she is going to say and do, the two of you may well have a conversation, but it is probably not a dialogue. Only clients can change themselves. Helpers influence and facilitate change through effective dialogue. Co-creation of outcomes still leaves clients "in the driver's seat."

Although individual communication skills are a necessary part of communication competence, dialogue together with the collaboration it fosters is the integrating mechanism. Of course, this means dialogue informed by and permeated with the values outlined in Chapter 3. Effective dialogue is both respectful and empathic, helps clients better understand and own their problems, and helps them engage in problem-managing change. Exploitative dialogue is a contradiction in terms. But enough about the "technology" of dialogue. Roy (2017) in a short but engaging article on the power and deep humanity of dialogue, sums things up nicely: "Dialogue reveals all that is said, unsaid, and unsayable."

## Demonstrate Empathic Presence by Visibly Tuning In to Clients **LO 4.3**

During some of the more dramatic moments of life, simply being with another person is extremely important. If a friend of yours is in the hospital, just your being there can make a difference, even if conversation is impossible. Similarly, being with a friend who has just lost his partner can be very comforting to him, even if little is said. Your empathic presence is comforting. Most people appreciate it when others pay attention to them. By the same token, being ignored is often painful: The averted face is too often a sign of the averted heart. Given how sensitive most of us are to others' attention or inattention, it is paradoxical how insensitive we can be at times about paying attention to others.

Helping and other deep interpersonal exchanges demand a certain robustness or intensity of presence. Visibly tuning in to others contributes to this presence. It is an expression of empathy that tells clients that you are with them, and it puts you in a position to listen carefully to their concerns. Your attention can be manifested in both physical and psychological ways. Because nonverbal behavior can play an important part in empathic communication, let's start by briefly exploring nonverbal behavior as a channel of communication.

### Adopt Basic Guidelines for Visibly Tuning In to Clients

There are certain key nonverbal skills you can use to visibly tune in to clients. Some of these skills can be summarized in the acronym SOLER. Because communication skills are particularly sensitive to cultural differences, care should

be taken in adapting what follows to different cultures. What follows is only a framework.

**S: Face the client Squarely** That is, adopt a posture that indicates involvement. In North American culture, facing another person squarely is often considered a basic posture of involvement. It usually says, “I’m here with you; I’m available to you.” Turning your body away from another person while you talk to him or her can lessen your degree of contact with that person. Even when people are seated in a circle, they usually try in some way to turn toward the individuals to whom they are speaking. The word squarely here should not be taken too literally. “Squarely” is not a military term. The point is that your bodily orientation should convey the message that you are involved with the client. If, for any reason, facing the person squarely is too threatening, then an angled position may be more helpful. The point is not inches and angles but the quality of your presence. Your body sends out messages whether you like it or not. Make them congruent with what you are trying to do.

**O: Adopt an Open posture** Crossed arms and crossed legs can be signs of lessened involvement with or availability to others. An open posture can be a sign that you are open to the client and to what he or she has to say. In North American culture, an open posture is generally seen as a non-defensive posture. Again, the word open can be taken literally or metaphorically. If your legs are crossed, this does not mean that you are not involved with the client. But it is important to ask yourself, “To what degree does my present posture communicate openness and availability to the client?” If you are empathic and open-minded, let your posture mirror what is in your heart.

**L: Remember that it is possible at times to Lean toward the other** Watch two people in a restaurant who are intimately engaged in conversation. Very often they are both leaning forward over the table as a natural sign of their involvement. The main thing is to remember that the upper part of your body is on a hinge. It can move toward a person and back away. In North American culture, a slight inclination toward a person is often seen as saying, “I’m with you, I’m interested in you and in what you have to say.” Leaning back (the severest form of which is a slouch) can be a way of saying, “I’m not entirely with you” or “I’m bored.” Leaning too far forward, however, or doing so too soon, may frighten a client. It can be seen as a way of placing a demand on the other for some kind of closeness or intimacy. In a wider sense, the word lean can refer to a kind of bodily flexibility or responsiveness that enhances your communication with a client. And bodily flexibility can mirror mental flexibility.

**E: Maintain good Eye contact** In North American culture, fairly steady eye contact is not unnatural for people deep in conversation. It is not the same as staring. Again, watch two people deep in conversation. You may be amazed at the amount of direct eye contact. Maintaining good eye contact with a client is another way of saying, “I’m with you; I’m interested; I want to hear what you have to say.” Obviously, this principle is not violated if you occasionally look away. Indeed, you have to if you don’t want to stare. But if you catch yourself looking away frequently,

your behavior may give you a hint about some kind of reluctance to be with this person or to get involved with him or her. Or it may say something about your own discomfort. In other cultures, however, too much eye contact, especially with someone in a position of authority, is out of order. We have learned much about the cultural meaning of eye contact from our Asian students and clients.

***R: Try to be relatively Relaxed or natural in these behaviors*** Being relaxed means two things. First, it means not fidgeting nervously or engaging in distracting facial expressions. The client may wonder what's making you nervous. Second, it means becoming comfortable with using your body as a vehicle of personal contact and expression. Your being natural in the use of these skills helps put the client at ease.

A counselor trained in the *Skilled Helper* was teaching counseling to visually impaired students in the Royal National College for the Blind. Most of her clients were visually impaired. However, she wrote this about SOLER:

In counseling students who are blind or visually impaired, eye contact has little or no relevance. However, attention on voice direction is extremely important, and people with a visual impairment will tell you how insulted they feel when sighted people are talking to them while looking somewhere else. I teach SOLER as part of listening and attending skills and can adapt each letter of the acronym [to my visually impaired students] with the exception of the E. . . . After much thought, I would like to change your acronym to SOLAR, the A being for "Aim," that is, aim your head and body in the direction of your client so that when they hear your voice, be it linguistically or paralinguistically, they know that you are attending directly to what they are saying. (personal communication)

This underscores the fact that people are more sensitive to how you orient yourself to them nonverbally than you might imagine. Anything that distracts from your "being there" can harm the dialogue. The point to be stressed is that a respectful, empathic, genuine, and caring mind-set might well lose its impact if the client does not see these internal attitudes reflected in your external behaviors.

In the beginning you may become overly self-conscious about the way you visibly tune in, especially if you are not used to being attentive. Still, the guidelines just presented are just that—guidelines. They should not be taken as absolute rules to be applied rigidly in all cases. Box 4.1 summarizes, in question form, the main points related to being visibly tuned in to clients. Please use the *Exercises in Helping Skills* in MindTap® for opportunities to "practice" the skill of visibly tuning in. Every conversation you have is an opportunity to practice.

## **Use Nonverbal Behavior as a Channel of Communication**

Some people limit their interpersonal effectiveness by failing to recognize and read the nonverbal messages of others and/or fail to use nonverbal behavior to send or modulate messages to others (Manusov, 2005; Manusov & Patterson, 2007). For instance, Terrence does not see the signs of boredom in others when he engages in endless monologues. And Cynthia wonders why others remain unaffected by what she says, but she does not use nonverbal behavior to give zest to her messages. Over the years both researchers and practitioners have come to appreciate the importance of nonverbal behavior both in daily life (Burgoon,

**BOX 4.1****Questions on Visibly Tuning In**

- What are my attitudes toward this client?
- How would I rate the quality of my presence to this client?
- To what degree does my nonverbal behavior indicate a willingness to work with the client?
- What attitudes am I expressing in my nonverbal behavior?
- What attitudes am I expressing in my verbal behavior?
- To what degree does the client experience me as effectively present and working with him or her?
- To what degree does my nonverbal behavior reinforce my internal attitudes?
- In what ways am I distracted from giving my full attention to this client? What am I doing to handle these distractions? How might I be more effectively present to this person?

Guerrero, & Floyd, 2009; Knapp, Hall, & Horgan, 2014; Pease & Pease, 2006) and in counseling (Dowell & Berman, 2013; Philippot, Feldman, & Coats, 2003; Richmond, McCroskey, & Hickson, 2012). Feldman (2014) edited a book that looks at nonverbal behavior in a wide variety of settings. And there is the *Journal of Nonverbal Behavior* with theory- and research-based articles in all areas of nonverbal behavior. Although the literature dealing with nonverbal behavior in all the settings of life is vast, only a few key principles are outlined here to get you started. Highlen and Hill (1984) outlined why the understanding and use of nonverbal behavior is important: nonverbal behaviors help regulate conversations, communicate emotions, modify or nuance verbal messages, provide important messages about the helping relationship, give insights into self-perceptions, and provide clues when clients (or counselors) are not saying what they are thinking. This area has taken on even more importance because of the multicultural nature of helping. David Givens (2017) of the Center for Nonverbal Studies has published an online nonverbal dictionary of gestures, signs, and body language cues. To assume that nonverbal behaviors mean the same thing across cultures is not only wrong, but sometimes dangerous. Watch what you do with your hands in different cultures.

The face and body are extremely communicative. We know from experience that even when people are together in silence, the atmosphere can be filled with messages. Sometimes clients' facial expressions, bodily motions, voice quality, and physiological responses communicate more than their words do. The following factors, on the part of both helpers and clients, play an important role in the therapeutic dialogue:

- Bodily behavior, such as posture, body movements, and gestures
- Eye behavior, such as eye contact, staring, eye movement
- Facial expressions, such as smiles, frowns, raised eyebrows, and twisted lips
- Voice-related behavior, such as tone of voice, pitch, volume, intensity, inflection, spacing of words, emphases, pauses, silences, and fluency



- Observable autonomic physiological responses, such as quickened breathing, blushing, paleness, and pupil dilation
- Physical characteristics, such as fitness, height, weight, and complexion
- Space, that is, how close or far a person chooses to be during a conversation
- General appearance, such as grooming and dress

People constantly “speak” to one another through their nonverbal behavior. Effective helpers learn this “language” and how to use it effectively in their interactions with their clients. They also learn how to “read” relevant messages embedded in the nonverbal behavior of their clients. Clients’ nonverbal behavior will be addressed later in the chapter.

### **Learn to Read the Signals That Both You and Your Clients Are Sending**

Before you begin interpreting the nonverbal behavior of your clients, take a look at yourself. You speak to your clients through all the nonverbal categories outlined above. At times your nonverbal behavior is as important as, or even more important than, your words. Your nonverbal behavior influences clients for better or for worse. Clients read in your nonverbal behavior cues that indicate the quality of your presence to them. Attentive presence can invite or encourage them to trust you, open up, and explore the significant dimensions of their problem situations. Half-hearted presence can promote distrust and lead to clients’ reluctance to reveal themselves to you. Clients may misinterpret your nonverbal behavior. For instance, you may be comfortable with the space between you and your client, but it is too close for the client. Or remaining silent might in your mind mean giving a client time to think, but the client may interpret the silence as judgment or as a sign of indifference. Part of listening, then, is being sensitive to clients’ reactions to your nonverbal behavior.

Effective helpers are mindful of, but not preoccupied with, the stream of nonverbal messages they send to clients. Reading your own bodily reactions is an important first step. For instance, if you feel your muscles tensing as the client talks to you, you can say to yourself, “I’m getting anxious here. What’s going on? And what nonverbal messages indicating my discomfort am I sending to the client?” Again, you probably would not use these words. Rather you read the signals your body is sending you without letting them distract you from your client.

You can also use your body to censor instinctive or impulsive messages that you feel are inappropriate. For instance, if the client says something that instinctively angers you, you can control the external expression of the anger (for instance, a sour look) in order to give yourself time to reflect. Such self-control is not phony because your respect for your client takes precedence over your instinctive reactions. Not dumping your annoyance or anger on your clients through nonverbal behavior is not the same as denying it. Becoming aware of it is the first step in dealing with it.

In a more positive vein, you can “punctuate” what you say with nonverbal messages. For instance, Denise is especially attentive when Jennie talks about actions she could take to do something about her problem situation. She leans forward, nods, and says “uh-huh.” She uses nonverbal behavior to reinforce, let’s say, Jennie’s intention to act constructively in renewing contact with a couple of key friends.



On the other hand, don't become preoccupied with your body and the qualities of your voice as a source of communication. Rather, learn to use your body instinctively as a means of communication. Being aware of and at home with nonverbal communication can reflect an inner peace with yourself, the helping process, and your clients. Your nonverbal behavior should enhance rather than stand in the way of your working alliance with your clients. Of course, it takes time to develop awareness of both the process of what is occurring within yourself and to be fully present with the person sitting in front of you. Through practice, however, such awareness can become second nature.

Although the skills of visibly tuning in can be learned, they will be phony if they are not driven by the values such as respect and empathy discussed in Chapter 3. Your mind-set—what's in your heart—is as important as your visible presence. If you are not actively interested in the welfare of your client or if you resent working with a client, subtle or not-so-subtle nonverbal clues will color your behavior. For example, imagine a patient mentions to a doctor his concerns about an invasive diagnostic procedure she intended to use. The doctor said the right words to reassure him, but her physical presence and the way she rushed her words said, "I've heard this dozens of times. I really don't have time for your concerns. Let's get on with this." Her words were right but the real message was in the nonverbal messages that accompanied her words.

Ants and bees send signals to one another in swarms and hives and use these signals not only to "talk" to one another but also to make life-enhancing "decisions." Of course, the signals are nonverbal. Current research (Buchanan, 2009; Pentland, 2008, 2010; Skinner, Meltzoff, & Olson, 2016) indicates that people do the same. In therapy, these signals constitute part of the social influence dimensions of helping mentioned in Chapter 3. Pentland organizes the "honest signals"—they are "honest" because they are largely automatic, autonomic, and unconscious—that we send to one another into four categories—activity, interest, mimicry, and consistency. Take activity. Both clients and helpers display more nervous energy when they become more active. Each party can pick up these signals. Or take interest. You can tell the level of interest ("skin in the game") people have in what they are doing by reading how attentive they are to each other. This attention enables them to anticipate when the other person has made his or her point and finds the opportune moment to jump in. Pentland and his colleagues have developed technologies that enable them to read and measure this signaling process. Honest signals are hard to fake and they do influence the other person. The kind of person—the kind of helper—you are comes across through these signals and are read by your clients. Genuineness cannot be faked. The point here is that nonverbal signals are at the heart of dialogue and not just conversational niceties. The fact that signals are being sent, received, and acted on "in the shadows" adds a note of uncertainty to the dialogue, but, as Duncan (2010) noted in Chapter 1, uncertainty has an upside.

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## Make Active Listening the Foundation of Understanding **LO 4.4**

Visibly tuning in to clients is not, of course, an end in itself. We tune in both mentally and visibly in order to listen to what clients have to say—their stories, complaints, points of view, intentions, proposals, decisions, and everything else. Listening carefully to a client’s concerns seems to be a concept so simple to grasp and so easy to do that one may wonder why it is given such explicit treatment here. Nonetheless, people often fail to listen to one another. Listening, as noted earlier is a critical communication component that we often leave to chance. Interestingly (sadly?), it is a highly coveted commodity according to employers (Goby & Lewis, 2000), yet most colleges and universities don’t offer classes that address basic communication skills, including listening (Welch & Mickelson, 2013). Perhaps, it is because it seems so easy—“All you have to do is just listen.” If only it were that easy. Full listening means listening actively, listening accurately, and listening for meaning. Listening is not merely a skill. It is a rich metaphor for the helping relationship itself—indeed, for all relationships. We will attempt to tap into some of that richness here.

**Active listening** plays a key role in all human service endeavors. Take the doctor-patient relationship, for instance. Patients have two central concerns about their doctors—their medical competence and their ability to relate and communicate. Listening, then, is an important medical skill. Hippocrates told aspiring doctors to “listen to the patient, and the patient will tell you what is wrong.” Today, even though doctors use sophisticated high-tech diagnostic methods together with a hands-on approach in making their diagnoses, listening to patients is still an extremely important part of health care. If Hippocrates were living, I’m sure that he would still be giving the same advice to doctors. Contemporary research supports this (Wanzer, Booth-Butterfield, & Gruber, 2004).

### Avoid Forms of Poor Listening

Effective listening is not a state of mind, like being happy or relaxed. It’s not something that “just happens.” It’s an activity. In other words, effective listening requires work. However, we get distracted, bored, tired, judgmental (e.g., “He is whining”), or sometimes simply forget that listening requires focus and effort. All of us have been, at one time or another, both perpetrators and victims of inactive or inadequate listening. Let’s take a look at the different forms in which poor listening can occur.

**Non-listening** Sometimes we go through the motions of listening but are not really engaged. At times we get away with it. Sometimes we are caught. “What

would you do?" Jennifer asks her colleague, Kieran, after outlining a problem the university counseling center is having with a sudden increase in requests for help. Embarrassed, Kieran replies, "I'm not sure." Staring him down, she says, "You haven't been listening! Where have you been the last ten minutes?" For whatever reason, he had tuned her out. Obviously no helper sets out not to listen, but even the best can let their mind wander as they listen to the same kind of stories over and over again, forgetting that the story is unique to this client.

**Partial listening** This is listening that skims the surface. We pick up bits and pieces, but not necessarily the essential points the person is making. Alicia, is meeting late in the afternoon with her advisor, Dr. Tyler, to talk about where to find funding for her last year of graduate school. She is anxious and concerned. Dr. Tyler, who thinks highly of Alicia, just received an e-mail he has been waiting on as she walks in the door. Being polite, he closes the e-mail and welcomes her, but he is *so* curious about the unread e-mail. Alicia quickly begins to explain how her current funding has unexpectedly ended and is now frantically trying to find another assistantship on campus. She is emotional and says she may even have to delay finishing school because of day care costs and being a single mother. Dr. Tyler, leaning back in his office chair, says "Uh huh" multiple times. Only when prompted more directly, "Do you have any ideas about what I should do next?" does Dr. Tyler spring forward and try to summarize what she had said and ask, "So, you are sure that you won't have funding next year (the only part he heard)?" His response missed the mark and suggested he was not fully paying attention. Alicia's anxiety increased and she left his office feeling unheard, and even worse, uncared about.

**Audio-recorder listening** What clients look for from listening is not the helper's ability to repeat their words. Any kind of recorder could do that perfectly. People want more than physical presence in human communication; they want the other person to be present psychologically, socially, and emotionally. Sometimes helpers fail to visibly tune in and listen; they are not totally present. Clients pick up on signs of nonlistening and lack of total presence. How many times have you heard someone exclaim, "You're not listening to what I'm saying!" When the person accused of not listening answers, almost predictably, "I am too listening; I can repeat everything you've said," the accuser is not comforted. Usually clients are too polite or cowed or preoccupied with their own concerns to say anything when they find themselves in that situation. But it is a shame if your auditory equipment is in order, but you are elsewhere. Your clients want you, a live counselor, not a recorder.

**Rehearsing** Picture Jonathan, a novice counselor, sitting with Casey, a client who is talking about some "wild dreams" he is having. Jonathan says to himself, "I don't believe that it's possible to extract any kind of meaning from dreams. It's all speculation." He fails to realize that Casey is really disturbed by his dreams. He can capture his client's strong emotion without resolving the meaning-of-dreams issue. Even when experienced helpers begin to mull over how they will respond to the client, they stop listening. On the other hand, effective helpers listen intently to clients and to the themes and core messages embedded in what clients are saying. They do not need to rehearse. And their responses are much more likely to help

clients move forward in the problem-management process. When the client stops speaking, they often pause to reflect on what he or she just said, and then speak. Pausing says, “I’m still mulling over what you’ve just said. It seems to move the problem in a different direction. Let me see if I can put my finger on what you’ve just said.” Effective helpers pause, not because they have not listened or have nothing to say. They pause because they have listened and want to respond helpfully.

### **Listen Carefully to Clients’ Stories in Terms of Experiences, Thoughts, Behaviors, and Feelings**

The opposite of inactive or inadequate listening is empathic listening, listening driven by the value of empathy. Empathic listening centers on the kind of attending, observing, and listening—the kind of “being with”—needed to develop an understanding of clients and their worlds. Although it might be metaphysically impossible to actually get “inside” the world of another person and experience the world as he or she does, it is possible to approximate this.

Carl Rogers (1980) talked passionately about basic empathic listening—being with and understanding the other—even calling it “an unappreciated way of being” (p. 137). He used the word unappreciated because in his view few people in the general population developed this “deep listening” ability and even so-called expert helpers did not give it the attention it deserved. Here is his description of empathic listening, or “being with”:

It means entering the private perceptual world of the other and becoming thoroughly at home in it. It involves being sensitive, moment by moment, to the changing felt meanings which flow in this other person, to the fear or rage or tenderness or confusion or whatever that he or she is experiencing. It means temporarily living in the other’s life, moving about in it delicately without making judgments. (p. 142)

Such empathic listening is selfless because helpers must put aside their own concerns to be fully with their clients. Of course, Rogers pointed out that this deeper understanding of clients remains sterile unless it is somehow communicated to them. Although clients can appreciate how intensely they are attended and listened to, they and their concerns still need to be understood. Empathic listening leads to empathic understanding, which leads to empathic responding.

Empathic participation in the world of another person obviously admits of degrees. As a helper, you must be able to enter clients’ worlds deeply enough to understand their struggles with problem situations or their search for opportunities with enough depth to make your participation in problem management and opportunity development valid and substantial. If your help is based on an incomplete or invalid understanding of the client, then your helping may lead him or her astray. If your understanding is valid but superficial, then you might miss the central issues of the client’s life.

The following case will be used to help you develop a better behavioral feel for empathic listening.

Jennie, an African American college senior, was raped by a “friend” on a date. She received some immediate counseling from the university Student Development Center and some ongoing support during the subsequent investigation. But even

though she was raped, it turned out that it was impossible for her to prove her case. The entire experience—both the rape and the investigation that followed—left her shaken, unsure of herself, angry, and mistrustful of institutions she had assumed would be on her side (especially the university and the legal system). When Denise, a middle-aged and middle-class African American social worker who was a counselor for a health maintenance organization (HMO), first saw her a couple of years after the incident, Jennie was plagued by a number of somatic complaints, including headaches and gastric problems. At work, she engaged in angry outbursts whenever she felt that someone was taking advantage of her. Otherwise she had become quite passive and chronically depressed. She saw herself as a woman victimized by society and was slowly giving up on herself.

Denise is a professional, so she does not have much of a problem with inadequate listening. She is an empathic listener par excellence. She is engaged by Jennie's story and by what Jennie is going through right now. In many ways helping is a "talking game." Therefore the kind and quality of talk are both crucial. Listening at its best is both focused and unbiased. Two forms of focus are offered here. First, the problem-management helping framework helps counselors organize what they are hearing. Problem-management and opportunity-development dialogue is at the heart of helping. Helpers listen intently to clients' stories to help them search for solutions, that is, life-enhancing outcomes.

The second aid to focused listening is having an organized view of person-ality. Pervin's (1996) definition of personality is "the complex organization of cognitions [thoughts], affects [emotion], and behaviors that gives direction and pattern (coherence) to the person's life" (p. 414). Rasmussen (2005), author of one of the books in a personality-guided therapy series (Everly & Lating, 2004; Farmer & Nelson-Gray, 2005; Harper, 2004; Magnativa, 2005), adds the notion of "activating event" (p. 4) to Pervin's triad. Because clients tell their stories in terms of their experiences (activating events), thoughts, behaviors, and emotions, we as helpers are listening to and "seeing" their personalities at work, as it were. More precisely, we are listening to both individual thoughts and patterns of thinking, to both individual behaviors and patterns of behaving, and to both individual emotions and patterns of emotionality—all stimulated by both internal and external experiences or events.

Clients' stories, then, tend to be mixtures of clients' experiences, thoughts, emotions, and behaviors. Bricker, Glat, and Stover (2007) claim that familiarity with this schema or framework fosters "clinical mindfulness" and helps counselors organize their work in order to keep therapy "moving toward objective, recognizable goals." They claim that the helper without any framework or schema for organizing what clients are saying risks "clinical drift" (all citations, p. 25).

- **Experiences.** Clients talk about their *experiences*—that is, what happens to them. If a client tells you that she was fired from her job, she is talking about her problem situation as an experience. Jennie, of course, talked about being raped, belittled, and ignored.
- **Thoughts.** Clients talk about the way they think and the *thoughts* that go through their head. Jennie shares her points of view about the rape and its aftermath. She thinks that the color of her skin worked against her.

- **Behavior.** Clients talk about their *behavior*—that is, what they do or refrain from doing. If a client tells you that he smokes and drinks a lot, he is talking about his external behavior. If a different client says that she spends a great deal of time daydreaming, she is talking about her internal behavior. Jennie talked about pulling away from her family and friends after the rape investigation.
- **Affect.** Clients talk about their *affect*—that is, the feelings, emotions, and moods that arise from or are associated with their experiences, thoughts, and both internal and external behaviors. If a client tells you how depressed she gets after fights with her fiancé, she is talking about the mood associated with her experiences and behavior. Jennie talked about her shame, her feelings of betrayal, and her anger.

Of course, thoughts, actions, and emotions are interrelated in the day-to-day lives of clients. And so they mix them together in telling their stories. Consider this example. A client is talking to a counselor in the personnel department of a large company. The client says in a very agitated way: “I’ve just had one of the lousiest days of my life.” At this point the counselor knows that something went wrong and that the client feels bad about it, but she knows relatively little about the specific experiences, thoughts, and behaviors that has made the day such a horror for the client. However, the client continues:

Toward the end of the day my boss yelled at me in front of some of my colleagues for not landing an order from a new customer [an experience]. I lost my temper [emotion] and yelled right back at him [behavior]. He blew up and fired me on the spot [an experience for the client]. I really think that he’s a jerk and the company should not tolerate people like him in supervisory positions [a thought, a point of view]. And now I feel awful [emotion] and am trying to find out if I really have been fired and, if so, if I can get my job back [behavior]. I have every intention to fight this; it’s unjust [a thought, a resolve, a point of view].

Now the counselor knows a great deal more about the problem situation. Problem situations are much clearer when they are spelled out as specific experiences, thoughts, behaviors, and feelings related to specific situations. Because clients spend so much time telling their stories, a few words about each of these elements are in order.

***Listen to clients’ experiences*** Most clients spend a fair amount of time, sometimes too much time, talking about what happens to them.

- “Companies don’t care about their employees anymore. We are just faceless cogs in the machine, why should I even care?”
- “I will never be able to trust anyone after what happened. I’ve learned it is just easier to not trust.”
- “It’s hard. Drugs are everywhere. They’re too easy to get.”
- “I get headaches a lot. They make it impossible for me to do anything.”

It is of paramount importance to listen to and understand clients’ experiences. However, because experiences often dwell on what other people do or fail to do, experience-focused stories at times are usually incomplete and, often enough, tinged with—or flooded with—victimhood. The implication is that others—or the world in general—are to blame for the client’s problems.



- “She doesn’t do anything all day. The house is always a mess when I come home. No wonder I can’t concentrate at work.”
- “He tells his little jokes, and I’m always the butt of them. He makes me feel bad about myself most of the time.”

Some clients talk about experiences that are internal and out of their control.

- “These feelings of depression come from nowhere and seem to suffocate me.”
- “I just can’t stop thinking about him.”

The last statement sounds like an action, but it is expressed as an experience. It is something happening to the client, at least to the client’s way of thinking.

One reason that some clients fail to manage the problem situations of their lives is that they are too passive or unable to move beyond seeing themselves as victims, adversely affected by other people, by the immediate social settings of life such as family, by society in its larger organizations and institutions such as government or the workplace, by cultural prescriptions, or even by internal forces. They feel that they are no longer in control of their lives or some dimension of life. Therefore, they talk extensively about these experiences.

- “Company policy discriminates against women. It is that simple.”
- “The economy is picking up, but the kinds of jobs I want are already taken.”
- “No innovative teacher gets very far around here.”

Of course, some clients *are* treated unfairly; they are victimized by the behaviors of others in the social and institutional settings of their lives. Although they can be helped to cope with victimization, full management of their problem situations demands changes in the social settings themselves. A counselor helped one client cope with a brutal husband, but ultimately the courts had to intervene to keep him at bay.

For other clients, talking constantly about experiences can be a way of avoiding responsibility: “It’s not my fault. After all, these things are happening to me.” Helpers need both to respect clients’ negative experiences and to help them move beyond them. Good helpers empathize but are also listening and working with clients to develop ways to help clients cope and maximize control of their lives.

***Listen to clients’ thoughts and patterns of thinking*** A lot goes on in clients’ heads. Common ways in which clients share their thinking include sharing points of view, stating intentions, declaring decisions, and offering proposals and plans.

***Clients’ points of view.*** As clients tell their stories, explore possibilities for a better future, set goals, make plans, and review obstacles to accomplishing these plans, they often share their points of view. A point of view is a client’s personal estimation of something. A full point of view includes the point of view itself, the reasons for it, an illustration to bring it to life, and some indication of how open the one holding the point of view might be to modifying it. If the client also expects others to adopt the point of view, then he or she is engaging in some form of selling or persuasion. But, realistically, the implication of a stated point of view often is: “I think this way. Why don’t other people think this way?” Or, “This is my opinion and I don’t care what other people think.” For instance,



Tom, an 88-year-old man, is talking to a counselor about his fears of losing his independence. At one point he says,

My kids, well my son and daughter are both in their 60s - but they are still *my* kids, are telling me I need to consider assisted living. They both worry too much. Since their mom passed last year, they think I can't take care of myself. I am definitely slower than I used to be, but I don't need anyone looking after me.

Tom's point of view is that his "kids'" concerns are unfounded, that their worrying is unnecessary. His son and daughter note his recent health setbacks, but Tom seems them as temporary and manageable. "I am fine. I still walk 2 miles every day, well most days. I'm not your normal 88-year-old."

*Points of view reveal clients' beliefs, values, attitudes, and convictions.* Clients may share their points of view about everything under the sun. You will need to listen to and understand those that are relevant to their problem situations or undeveloped opportunities. Let's return briefly to Jennie and Denise. Jennie says,

You just can't trust the system. They're not going to help. They take the easy way out. I don't care which system it might be. Church, government, the community, sometimes even the family. They're not going to give you much help. If you've got problems, then you become a problem to others.

Denise listens carefully to Jennie's point of view and realizes how much it is influencing her behavior. In Jennie's case it's easy to see where her point of view comes from given her experiences. But Denise also knows that at some point Jennie would benefit from exploring the consequences, however unintended, of that point of view. Jennie's point of view may be one of the things that is keeping her locked in her misery. Points of view have power, but the power can be either self-enhancing or self-limiting.

*Clients' intentions, proposals, and plans.* Clients provide a window into their thinking when they state intentions, offer proposals, or make a case for certain courses of action—all problem-management behaviors. Consider Lydia. She is a single parent of two young children and a member of the "working poor." Her wages don't cover her expenses. The father of her children has long disappeared. She says to a social worker,

I've been thinking of quitting my job. I'm making minimum wage and with travel expenses and all I just can't make ends meet. I spend too much time traveling and don't see enough of my kids. Friends look after them when I'm gone, but that just puts a burden on them. You know if I go on welfare I could make almost as much. And then I could pick up jobs that would pay me cash. I've got friends who do this. I believe I could make ends meet. My kids and I would be better off. And I wouldn't be hassled as much.

Lydia is making a case, but stops short of announcing a decision. The case includes what she wants to do (quit her job and move into the "alternate" work economy), the reasons for doing it (the inadequacy of her current work situation, the need to make ends meet), and the implications for herself and her children (she'd be less hassled and her kids would see more of her and be better off).

*Clients' decisions.* Helping clients with choices and also reviewing the decisions they have made is one of the key ingredients of successful therapy. Clients often

talk about decisions they are making or have already made. A client might say, “I’ve decided to stop drinking. Cold turkey.” Or, “I’m tired of being alone. I’m going to see if I can find someone on an online dating service.” Decisions usually have implications for the decision maker and for others. The client who has decided to quit drinking cold turkey has his work cut out for himself, but there are implications for his partner. For instance, she’s used to coping with a drunk, but now she may have to learn how to cope with this “new person” in the house.

Sharing a decision fully means spelling out the decision itself, the reasons for the decision, the implications for self and others, possible unintended consequences, and some indication as to whether the decision or any part of it is open to review. For instance, Jennie, talking with Denise about future employment, says in a rather languid tone of voice, “I’m not going to get any kind of job where I have to fight the race thing. Or the woman thing. I’m tired of fighting. I only get hurt. I know that this limits my opportunities, but I can live with that.” Note that this is more than a point of view. Jennie is more or less saying, “I’ve made up my mind.” She notes the implication for herself—a limitation of job opportunities—and an implication for Denise might be, “So that’s the end of it. Don’t try to convince me otherwise.” Denise hears the message and the implied command. However, she believes that some of Jennie’s messages need challenging. Decisions can be tricky. Often enough, how they are delivered says a great deal about the decision itself. Given the rather languid way in which Jennie delivers her decision, Denise thinks that it might not be Jennie’s final decision. This is something that has to be checked out. A dialogue with Jennie about the reasons for her decision and a review of its possible implications can add value.

***Listen to clients’ behaviors and patterns of behavior*** All of us do things that get us into trouble and fail to do things that will help us get out of trouble or develop opportunities. Clients are no different.

- “When he ignores me, I begin thinking of ways of getting back at him.”
- “Whenever anyone gets on my case for having a father in jail, I let him have it. I’m not taking that kind of crap from anyone.”
- “Even though I feel the depression coming on, I don’t take the pills the doctor gave me.”
- “When I get bored, I find some friends and go get drunk.”
- “I have a lot of sexual partners and have unprotected sex whenever my partner will let me.”

Some clients talk freely about their experiences, what happens to them, but seem more reluctant to talk about their behaviors. One reason for this is that it’s hard to talk about behaviors without bringing up, at least indirectly, issues of personal responsibility.

***Listen to the client’s feelings, emotions, and moods*** Feelings, emotions, and moods constitute a river that continually runs through us—peaceful, meandering, turbulent, or raging—often beneficial, sometimes dangerous, seldom neutral. Emotions, in one capacity or another, are typically the reason why clients seek counseling. Stress, anxiety, depression, regret, unhappiness, anger, sadness, and a host

of other emotions are often at the core of why help is sought. They are certainly an important part of clients' problem situations and undeveloped opportunities (Angus & Greenberg, 2017; Plutchik, 2001, 2003; Rottenberg & Johnson, 2007).

Recognizing key feelings, emotions, and moods (or the lack thereof) is very important for at least three reasons. First, they pervade our lives. There is an emotional tone to just about everything we do. Feelings, emotions, and moods pervade clients' stories, points of view, decisions, and intentions or proposals. Second, they greatly affect the quality of our lives. A bout of depression can stop us in our tracks. A client who gets out from under the burden of self-doubt breathes more freely. Third, feelings, emotions, and moods are drivers of our behavior. As Lang (1995) pointed out, they are "action dispositions" (p. 372). Clients driven by anger can do desperate things. On the other hand, enthusiastic clients can accomplish more than anyone ever thought they could. The good news is that we can learn how to tune in to our clients' emotions and moods and help them make sense of them and find ways of managing them. We can help them see how emotions are influencing them to make ill-considered decisions. On the other hand, we can help clients see how emotions can contribute to a fuller life. For instance, according to Mayer and Salovey (1997) emotional intelligence consists of four "branches": accurately perceiving emotions in oneself and others; using emotions to facilitate thought and understanding; understanding emotional meanings; and managing one's emotions effectively.

Understanding the role of feelings, emotions, and moods in clients' problem situations and their desire to identify and develop opportunities is central to the helping process. Emotions highlight learning opportunities.

- "I've been feeling pretty sorry for myself ever since she left me." This client learns that self-pity constricts his world and limits problem-managing action.
- "I yelled at my mother last night and now I feel very ashamed of myself." Shame may well be a wake-up call in this client's relationship with his mother.
- "I've been anxious for the past few weeks, but I don't know why. I wake up feeling scared and then it goes away but comes back again several times during the day." Anxiety has become a bad habit for this client. It is self-perpetuating. What can the client do to break through the vicious circle?
- "I finally finished the term paper that I've been putting off for weeks and I feel great!" Here emotion becomes a tool in this client's struggle against procrastination.

The last item in this list brings up an important point. In the psychological literature, negative emotions tend to receive more attention than positive emotions. Now work is under way to study positive emotions and their beneficial effects. There are indications that we can use positive emotions to promote both physical and psychological well-being (Fredrickson, 2001; Fredrickson, Mancuso, Branigan, & Tugade, 2000; Lyubomirsky, King, & Diener, 2005; Magyar-Moe, Owens, & Conoley, 2015; Salovey, Rothman, Detweiler, & Steward, 2000). Positive emotions can free up psychological resources, act as opportunities for learning, and promote health-related behaviors. Fredrickson's (2001) broaden-and-build theory highlights that positive feelings such as joy or optimism can increase creativity and problem solving (broadening) which leads to new strategies and ways to view a problem or situation (build).

Of course, clients often express feelings without talking about them. When a client says, “My boss gave me a raise and I didn’t even ask for one!” you can feel the emotion in her voice. A client who is talking listlessly and staring down at the floor may not say, in so many words, “I feel depressed.” A dying person may express feelings of anger and depression without talking about them. Other clients feel deeply about things but do their best to hold their feelings back. But effective helpers can usually pick up on clues or hints, whether verbal or non-verbal, that point to the feelings and emotions rumbling inside.

Clients’ stories, points of views, decisions, and expressed intentions or proposals for action are permeated by feelings, emotions, and moods. Your job is to listen carefully to the ways in which they affect, color, and give meaning to words they are using. The meaning is not just in the words. It’s in the full package. In order to name the range and subtleties of emotions that you are feeling and clients are expressing, you need the experience and the vocabulary to do so. Plutchik (2001, 2003) uses brightly colored graphics depicting a wide range of emotions arranged around eight basic emotions. Take a look.

***Listen for strengths, opportunities, and resources*** If you listen only for problems, you will end up talking mainly about problems. And you will shortchange your clients. Every client has something going for him or her. Your job is to spot clients’ resources and help them invest these resources in managing problem situations and opportunities. If it is true that people generally use only a fraction of their potential (Maslow, 1968), then there is much to be tapped. For instance, a counselor is working with a 65-year-old, successful businessman who, with his wife, has raised three children. The children are well-educated and successful in their own right. The man is having difficulty coping with some health problems. The counselor learns that the man was one of a group of poor inner-city boys in a longitudinal study. The boys had a mean IQ of 80 and a lot of social disadvantages (see Vaillant, 2000). As the counselor listens to the man’s story, he hears a history of resilience. The counselor helps him review the strategies he used to cope as he was growing up. Energized by this, the man says, “I never gave up then. Why should I start giving up now?”

One section of the positive psychology movement focuses on strengths, especially strengths that clients have but fail to use as they struggle with problem situations (Aspinwall & Staudinger, 2003; Bolt & Dunn, 2014; Peterson & Seligman, 2004). Just the list of the strengths examined in a book on “positive psychological assessment,” edited by Lopez and Snyder (2003), gives the reader a lift—hope, optimism, self-efficacy, problem-solving, internal locus of control, creativity, wisdom, courage, positive emotions, self-esteem, love, emotional intelligence, forgiveness, humor, gratitude, faith, morality, coping, and well-being. Listening for hints of any or all of these capabilities in our clients is a first step. Finally, all of these writers are committed to developing a science of human strengths.

***Listen to clients’ nonverbal messages and modifiers*** Carton, Kessler, and Pape (1999) showed that the ability of people to read nonverbal messages is one factor in establishing and maintaining relationships. So once we have an understanding of our own nonverbal “speech,” we can turn to an exploration of clients’ nonverbal behavior. Clients send a steady stream of clues and messages through their nonverbal behavior. Helpers need to learn how to read these messages

without distorting or over interpreting them. For instance, when Denise says to Jennie, “It seems that it’s hard talking about yourself,” Jennie says, “No, I don’t mind at all.” But the real answer is probably in her nonverbal behavior, for she speaks hesitatingly while looking away and frowning. Reading such cues helps Denise understand Jennie better. Our nonverbal behavior has a way of “leaking” messages about what we really mean. The very spontaneity of nonverbal behavior contributes to this leakage even in the case of highly defensive clients. It is not easy for clients to fake nonverbal behavior (Wahlsten, 1991).

Besides being a channel of communication in itself, such nonverbal behavior as facial expressions, bodily motions, and voice quality often modify and punctuate verbal messages in much the same way that periods, question marks, exclamation points, and underlining punctuate written language. All the kinds of nonverbal behavior mentioned earlier in this chapter can punctuate or modify verbal communication in the following ways:

- *Confirming or repeating.* Nonverbal behavior can confirm or repeat what is being said verbally. For instance, once when Denise responds to Jennie with just the right degree of understanding—she hits the mark—not only does Jennie say, “That’s right!” but also her eyes light up (facial expression), she leans forward a bit (bodily motion), and her voice is very animated (voice quality). Her nonverbal behavior confirms her verbal message.
- *Denying or confusing.* Nonverbal behavior can deny or confuse what is being said verbally. When challenged by Denise, Jennie denies that she is upset, but her voice falters a bit (voice quality) and her upper lip quivers (facial expression). Her nonverbal behavior carries the real message.
- *Strengthening or emphasizing.* Nonverbal behavior can strengthen or emphasize what is being said. When Denise suggests to Jennie that she ask her boss what he means by her “erratic behavior,” Jennie says in a startled voice, “Oh, I don’t think I could do that!” while slouching down and putting her face in her hands. Her nonverbal behavior underscores her verbal message.
- *Adding intensity.* Nonverbal behavior often adds emotional color or intensity to verbal messages. When Jennie tells Denise that she doesn’t like to be confronted without first being understood and then stares at her fixedly and silently with a frown on her face, Jennie’s nonverbal behavior tells Denise that her feelings are intense.
- *Controlling or regulating.* Nonverbal cues are often used in conversation to regulate or control what is happening. Let’s say that in a group counseling session, Nina looks at Tom and gives every indication that she is going to speak to him. But he looks away. Nina hesitates and then decides not to say anything. Tom has used a nonverbal gesture to control her behavior.

In reading nonverbal behavior—“reading” is used here instead of “interpreting”—caution is a must. We listen to clients in order understand them, not to dissect them. But merely noticing nonverbal behavior is not enough. Trainees can learn how to identify useful nonverbal messages, clues, and modifiers by watching videotaped interactions, including their own interactions (Costanzo, 1992). Once you develop a working knowledge of nonverbal behavior and its possible meanings, the next step is practice.

Because nonverbal behaviors can often mean a number of things, how can you tell which meaning is the real one? The key is the context in which they take place. Effective helpers listen to the entire context of the helping interview and do not become overly fixated on details of behavior. They are aware of and use the nonverbal communication system, but they are not seduced or overwhelmed by it. Sometimes novice helpers will fasten selectively on this or that bit of nonverbal behavior. For example, they will make too much of a half-smile or a frown on the face of a client. They will seize upon the smile or the frown and, in over interpreting it, lose the person.

### **Put It All Together by Listening to the Client's Integrated Narrative**

When clients talk about their concerns, they mix all forms of discourse—thoughts, stories, experiences, emotions, actions, evolving decisions, points of view, proposed actions, strengths, and resources—together. This is the client's narrative, their "story." Some lessons from the narrative therapy movement (Angus & McCloud, 2007; Brown & Augusta-Scott, 2006; Madigan, 2011; Payne, 2006; White, 2007) can help you help clients integrate this mix into a coherent story. Narrative therapy focuses on clients' understanding of their stories and how their experiences, thoughts, emotions, and actions fit into the context of the story. This approach can help clients do three things: put "untold" aspects of their past into the life narrative, emotionally enter and reauthor their own stories, and/or construct new meanings in old stories or find new meaning in stories that emerge during therapy. While narrative therapy is often associated with philosophical theories such as constructivism and postmodernism, these issues are not relevant here. Narrative therapy is not a separate therapy. It is an integral part of all therapy.

At the beginning of therapy Denise realizes that Jennie's story contains many self-limiting and even self-defeating themes. Later, Jennie, with Denise's help, begins to "reauthor" her story and new life-enhancing themes begin to emerge. For example, what follows came out through dialogue in one of Jennie's sessions with Denise. However, for the sake of illustration, it is presented here in summary form in Jennie's words. She is talking much more animatedly and maintains much more eye contact with Denise than she usually does.

A couple of weeks ago I met a woman at work who has a story similar to mine. We talked for a while and got along so well that we decided to meet outside of work. I had dinner with her last night. She went into her story in more depth. I was amazed. At times I thought I was listening to myself! Because she had been hurt, she was narrowing her world down into a little patch so that she could control everything and not get hurt anymore. I saw right away that I'm trying to do my own version of the same thing. I know you've been telling me that, but I haven't been listening very well. Here's a woman with lots going for her and she's hiding out. As I came back from dinner I said to myself you've got to change. So I want to revisit two areas we've talked about—my work life and my social life. I don't want to live in the hole I've dug for myself. I could see clearly some of the things she should do. So here's what I want to do. I want to engage in some little experiments in broadening my social life. Starting with my family. And I want to discuss the kind of work I want without putting all the limitations on it. I want to start coming out of the hole I'm in. And I want to help my new friend do the same.



Everything is here—a story about her new friend, including experiences, actions, and feelings; points of view about her new friend; decisions about where she wants her life to go; proposals about experiments in her social life and in her relationship with her friend. The new narrative, focusing now on a different set of experiences, thoughts, emotions, and actions, begins to emerge. The point is this: Developing frameworks for listening can help you zero in on the key messages your clients are communicating and help you identify and understand the feelings, emotions, and moods that permeate them. The narrative construct helps you help clients integrate all these elements into a coherent picture.

While listening is important, there is no need to go overboard on listening. Remember that you are a human being listening to a human being, not a vacuum cleaner indiscriminately sweeping up every scrap of information. Effective dialogic listening helps both you and your client discover the kind of meaning needed to move forward in managing problem situations and spotting and developing life-enhancing opportunities.

### **Process What You Hear in a Thoughtful Search for Meaning**

As we listen, we process what we hear. The trick is to become a thoughtful processor. As we shall see a bit further along, there are many less-than-thoughtful ways of processing clients' stories, points of view, and messages. But first, what does thoughtful processing look like? Here are some guidelines.

***Understand clients through context*** People are more than the sum of their verbal and nonverbal messages. Listening, in its deepest sense, means listening to clients themselves as influenced by the contexts in which they “live, move, and have their being.” As mentioned earlier, it is important to interpret a client's nonverbal behavior in the context of the entire helping session. It is also essential to help clients understand their stories, points of view, and messages and the emotions that permeate them through the wider context of their lives. Tiedens and Leach (2004), in their edited book *The Social Life of Emotions*, develop the theme that emotions cannot be understood independently of the social relationships and groups in which they occur. All the things that make people different—culture, personality, personal style, ethnicity, key life experiences, education, travel, economic status, and the other forms of diversity discussed in Chapter 3—provide the context for the client's problems and unused opportunities. There are a number of development frameworks that can help you take a contextual frame of reference with your clients (Arnett, 2000; Egan & Cowan, 1979; Qualls & Abeles, 2000). A graduate program now in place for a number of years at the University of Michigan, called Personality and Social Contexts, explores the contexts in which people live out their lives and how these contexts influence their lives. Here is a short description of this course taken from the University of Michigan website.

The Personality & Social Contexts (P&SC) area is committed to the analysis and understanding of individuals with a focus on how social contexts affect people's development and well-being. . . . P&SC faculty and students examine the person through multiple lenses such as hormones, traits, race, gender, sexuality, and social identities. In the same way, research in the area focuses on many different types of



social contexts, including close/intimate relationships, families, schools, organizations, communities, history, economies, and cultures. This attention to both the micro and macro levels of analysis has been used to examine a range of issues such as social inequalities, stigma, and resilience.

Key elements of context become part of the client's story, whether they are mentioned directly or not. Effective helpers listen through this wider context without being overwhelmed by the details of it.

To return to our previous example, Denise tries to understand Jennie's verbal and nonverbal messages, especially the core messages, in the context of Jennie's life. As she listens to Jennie's story, Denise says to herself right from the start something like this:

Here is an intelligent African American woman from a conservative Catholic background. She has been very loyal to the church because it proved to be a refuge in the inner city. It was a gathering place for her family and friends. It provided her with a decent primary and secondary school education and a shot at college. She did very well in her studies. Initially college was a shock. It was her first venture into a predominantly white and secular culture. But she chose her friends carefully and carved out a niche for herself. Because studies were much more demanding, she had to come to grips with the fact that, in this larger environment, she was, academically, closer to average. The rape and investigation put a great deal of stress on what proved to be a rather fragile social network. Her life began to unravel. She pulled away from her family, her church, and the small circle of friends she had at college. At a time when she needed support the most, she cut it off. After graduation she continued to stay "out of community." Now she is underemployed as a secretary in a small company. This does little for her sense of personal worth.

Denise listens to Jennie through this context without assuming that it need define Jennie. The helping context is also important. Denise needs to be sensitive about how Jennie might feel about talking to a woman who is quite different from her and also needs to understand that Jennie might well have some misgivings about the helping professions.

In sum, Denise tries to pull together the themes she sees emerging in Jennie's story and tries to see these themes in context. She listens to Jennie's discussion of her headaches (experiences), her self-imposed social isolation (behaviors), and her chronic depression (feelings) against the background of her social history—the pressures of being religious in a secular society at school, the problems associated with being an upwardly mobile African American woman in a predominantly white male society. Denise sees the rape and investigation as social, not merely personal, events. She listens actively and carefully, because she knows that her ability to help depends, in part, on not distorting what she hears. She does not focus narrowly on Jennie's inner world, as if Jennie could be separated from the social context of her life. Finally, although Denise listens to Jennie through the context of Jennie's life, she does not get lost in it. She uses context both to understand Jennie and to help her manage her problems and develop her opportunities more fully.

**Identify key messages and feelings** Helpers must avoid information overload. A thoughtful search for meaning demands the identification of key factors, that

is, key not to some theory but key to the purpose of helping. Denise listens to what Jennie has to say early on about her past and present experiences, thoughts, actions, and emotions. She listens to Jennie's points of view and the decisions Jennie has made or is in the process of making. She listens to Jennie's intentions and proposals. Jennie tells Denise about an intention gone awry and the emotions that went with it: "When the investigation began, I had every intention of pushing my case, because I knew that some of the men on campus were getting away with murder. But then it began to dawn on me that people were not taking me seriously because I was an African American woman. First I was angry, but then I just got numb. . . ." Later, Jennie says, "I get headaches a lot now. I don't like taking pills, so I try to tough it out. I have also become very sensitive to any kind of injustice, even in movies or on television. But I've stopped being any kind of crusader. That got me nowhere." As Denise listens to Jennie speak, questions based on the listening frameworks outlined here arise in the back of her mind:

- "To what degree are both involved in discovering what is really important?"
- "How is the dialogue going?"
- "What are the main points here?"
- "What experiences and actions are most important?"
- "What themes are coming through?"
- "What is Jennie's point of view?"
- "What is most important to her?"
- "What does she want me to understand?"
- "What decisions are implied in what she's saying?"
- "What is she proposing to do?"

Feedback surveys help Denise enormously to come up with answers to these questions. The questions in the survey do not mimic these questions. Rather they open up a give-and-take feedback process that enables both helper and client to bring up issues that have not been discussed directly. The soliciting of feedback ensures that both you and the client are on the same page (literally—if the surveys are used!).

### ***Do not avoid tough-minded listening and processing: Hear the slant or spin***

This is the kind of listening needed in order to help clients explore issues more deeply and to identify blind spots that need to be turned into new perspectives. Skilled helpers not only listen to clients' stories, points of view, decisions, intentions, and proposals but also to any slant or spin that clients might give their stories. Although clients' visions of and feelings about themselves, others, and the world are real and need to be understood, their perceptions are sometimes distorted.

For instance, if a client sees herself as ugly, her experience of herself as ugly is real and needs to be listened to and understood. If her experience does not square with the facts—if she is, in fact, nice looking—then this, too, must be listened to and understood. If a client sees himself as above average in his ability to communicate with others when, in reality, he is below average, his experience of himself needs to be listened to and understood, but reality cannot be ignored.

Tough-minded listening includes detecting the gaps, distortions, and dissonance that are part of the client's experienced reality.

Denise realizes from the beginning that some of Jennie's understandings of herself and her world are not accurate. For instance, in reflecting on all that has happened, Jennie remarks that she probably got what she deserved. When Denise asks her what she means, she says, "My ambitions were too high. I was getting beyond my place in life." This is the slant or spin Jennie gives to her career aspirations. It is one thing to understand how Jennie might put this interpretation on what has happened; it is another to assume that such an interpretation reflects reality. To be client-centered, helpers must also be reality-centered.

***Muse on what is missing*** Clients often leave key elements out when talking about problems and opportunities. Having frameworks for listening can help you spot important things that are missing. For instance, they tell their stories but leave out key experiences, behaviors, or feelings. They offer points of view but say nothing about what's behind them or their implications. They deliver decisions but don't give the reasons for them or spell out the implications. They propose courses of action but don't say why they want to head in a particular direction, what the implications are for themselves or others, what resources they might need, or how flexible they are. As you listen, it's important to note what they put in and what they leave out.

For instance, when it comes to stories, clients often leave out their own behavior or their feelings. Jennie says, "I got a call from an old girlfriend last week. I'm not sure how she tracked me down. We must have chatted away for 20 minutes. You know, catching up." Because Jennie says this in a rather matter-of-fact way, it's not clear how she felt about it at the time or feels now. Nor is there any indication of what she might want to do about it—for instance, stay in touch.

In another session Jennie says, "I was talking with my brother the other day. He runs a small business. He asked me to come and work for him. I told him no. . . . By the way, I have to change the time of our next appointment. I forgot I've got a doctor's appointment." Denise notes the experience (being offered a job) and Jennie's behavior or reaction (a decision conveyed to her brother refusing the offer). But Jennie leaves out the reasons for her refusal or the implications for herself or her brother or their relationship and moves to another topic.

Note that this is not a search for the "hidden stuff" that clients are leaving unsaid. We all leave out key details from time to time. Rather, because Denise understands what full versions of stories, points of view, and messages look like, she notes what parts are missing. She then uses her clinical judgment—a large part of which is common sense—to determine whether or not to ask about the missing parts. For instance, when she asks Jennie why she refused her brother point-blank, Jennie says, "Well, he's a good guy and I'd probably like the work, but this is no time to be getting mixed up with family." This is one more indication of how restricted Jennie has allowed her social life to become. It may be that she has determined that support from her family is out of bounds. In later chapters you will find ways of helping clients fill out their stories with essential but missing details related to stories, points of view, and messages.

## Listen to Your Own Internal Conversation

The conversation helpers have with themselves during helping sessions is the “internal conversation.” To be an effective helper, you need to listen not only to the client but also to yourself. Granted, you don’t want to become self-preoccupied, but listening to yourself on a “second channel” can help you identify both what you might do to be of further help to the client and what might be standing in the way of your being with and listening to the client. It is a positive form of self-consciousness.

Here is an example of being tuned into the second channel. Tom, 22 years old, is about to graduate from a top-notch liberal arts college with a degree in business administration and is meeting with Elena, a career counselor who is a 62-year-old Latina woman and retired executive. Tom says he is having a “quarter-life crisis,” noting, “I feel overwhelmed by the decisions I have to make. It is so tough.” Elena, who put herself through school as a single mother of two small children, feels her “eyes roll” internally. She thinks, “Quarter-life crisis? Whatever. Overwhelmed? You really have no idea.” She crosses her arms and gently leans back into her chair away from Tom. However, she catches herself, acknowledges her nonverbal behavior and internal dialogue, realizing she has not tuned in to his story and knows nothing about Tom or what is behind Tom’s statement. Instead she leans back in and probes, “There must be a lot for you to consider right now with graduation right around the corner.” He says, “A ton of stuff it feels like. I just feel, I don’t know, I guess betrayed that I have kept my head down and worked so hard only to look up and see what seems like an impossible job market. I paid my way through school and now I am worried about how I will pay back my loans much less find a job that will be interesting to me and pays anything. Makes me question why I picked this fancy pants school and majored in business in the first place.” Imagine if Elena had not listened to her “second channel”—it is likely their conversation would have gotten off-track in a hurry.

Helpers can use this second channel to listen to what they are “saying” to themselves, their nonverbal behavior, and their feelings and emotions. These messages can refer to the helper, the client, or the relationship.

- “I’m letting the client get under my skin. I had better do something to reset the dialogue.”
- “My mind has been wandering. I’m preoccupied with what I have to do tomorrow. I had better put that out of my mind.”
- “Here’s a client who has had a tough time of it, but her self-pity is standing in the way of her doing anything about it. My instinct is to be sympathetic. I need to talk to her about her self-pity, but I had better go slow.”
- “It’s not clear that this client is interested in changing. It’s time to test the waters.”

The point is that this internal conversation goes on all the time. It can be a distraction or it can be another tool for helping. In one study, Fauth and Williams (2005) found that helpers’ internal conversations were “generally helpful rather than hindering from both the trainee and student-client perspectives” (p. 443). The client, too, is having his or her internal conversation. One intriguing study (Hill, Thompson, Cogar, & Denman, 1993) suggested that both client and

therapist are more or less aware of the other's "covert processes." This study showed that even though helpers knew that clients were having their own internal conversations and left things unsaid, they were not very good at determining what those things were. At times there are verbal or nonverbal hints as to what the client's internal dialogue might be. Helping clients move key points from their internal conversations into the helping dialogue is a key task and will be discussed in a later chapter.

## Listen to the Key Ingredients of Successful Therapy LO 4.5

In counseling sessions we can "listen" to the key ingredients of successful therapy outlined in Chapter 1. This means tracking the presence of the key ingredients to make sure we are delivering the right "package" or mix of ingredients to *this* client.

### Listen to the Client

We give our full attention to our clients and listen carefully to: what they see as important, their stories, their expectations, their resources, their degree of collaboration, their struggle with obstacles, their ability to express their concerns, their reactions to their helpers, their willingness or hesitation to be in the driver's seat, the outcomes they are looking for, their understanding of and willingness to participate in the mode of treatment being used, the emotions they express, their uncertainties and hesitations, the contextual factors that affect their problems, unused opportunities, and participation. Denise listens carefully to the signs of hope in what Jennie says and does, especially her "tiny steps" toward moving back into community. Laura listens to how Karl emphasizes how helpful his phone and Internet interactions with Peter, his PTSD "buddy," are.

### Listen to Your Own Thoughts, Feelings, and Behaviors

We listen to the ways we impact our clients, our own uncertainties and hesitations, how we are being affected by the client, the difficulties that arise, the mistakes we make, our own emotions, how genuine we are, the effectiveness of our treatment method—and we do all this without becoming preoccupied with ourselves. Laura comes to grips with the fact the Karl's relationship with Peter seems to be producing better or more results than Karl's relationship with her. She does so by recognizing client outcomes are the bottom line, no matter how they are achieved. She knows her relationship to Karl is solid. If his relationship with Peter is "better" in some sense of the term, so be it. The relationship is not an end in itself. Denise, listening to all Jennie's resources, feel that she needs to encourage Jennie to move even more aggressively into the driver's seat because Jennie is showing signs that that is what she wants to do.

### Listen to What's Happening in the Relationship

Effective helpers listen carefully to the relationship-in-progress to discover which factors are working and which need attention; to the kind and quality of collaboration being developed; to the quality of the dialogue; to the ways they and their clients are influencing each other; to any "bumps in the road" that arise; to the ways in which the bumps or ruptures are handled. Laura sees cues indicating

that Karl sees her as an authority figure to be managed rather than a helper-collaborator-catalyst. When she asks, “How are we doing?”, she inevitably gets a response such as “We are doing just fine” or something like that. He keeps her at arm’s length. Because there is every sign that he is making progress, she hesitates to push the issue. Good outcomes trump ideal relationships.

### **Listen to the Flow of Communication Skills and Dialogue**

Helpers listen to how effectively they and their clients are collaborating through dialogue. Listening to how clients respond to what they say, counselors learn how to tailor their communication to the needs of clients. Helpers also listen to clients to discern their clients’ abilities as communicators. They then use their own communication skills unobtrusively to help clients engage as fully as possible in the dialogue. Denise recognizes Jennie’s communication skills as a resource to be used to get back into community. Karl is clumsier as a communicator. He has a tendency to see conversations, at least conversations with her, as a power game. She is not bothered because she has no need to be “one up” in any relationship. Furthermore, there seems to be little one-upmanship in Karl’s relationship with Peter. So it’s a question of leaving well-enough alone, at least for the time being.

### **Listen to the Two-Way Feedback between You and Your Client**

Helpers listen carefully to both formal and informal feedback with respect to both progress toward outcomes and quality of sessions. And they muse on it thoughtfully. Denise uses the formal feedback from the feedback surveys to explore any problematic issue. Laura listens carefully to all the “messages” being sent by Karl during their sessions. She “hears” his defensiveness and muses on what she might be doing to cause it. She learns more about the progress he is making by debriefing his sessions with Peter. And that progress seems to be substantial.

### **Listen to the Decisions Being Made**

Helpers listen to the overall decision-making style of their clients—for instance, whether they are, in Kahneman’s sense, they are “fast” or “slow” decision makers and fast or slow with respect to the right issues. Helpers look for signs that their clients have some idea of the consequences, intended or unintended, of the decisions they are making. Jennie tends to be more thoughtful in making decision but does not always review the consequences of her decisions. Karl is abrupt. Sometimes his decisions seem to come out of nowhere—for instance, his immediate rejection of feedback surveys, but, as it turned out, not the feedback process itself. Laura believes that his “fast” decision-making style can get him into trouble and wonders how to broach the issue with him. Helpers are also in touch with their own decision-making style in the flow of decisions involved in responding to clients. Denise wonders whether she tries to influence Jennie (and other clients) too much. Laura wonders whether she should be more forceful at times.

### **Listen to the Key Assumptions, Beliefs, Values, Norms, and Ethical Issues in Play**

The elements of this package, which includes culture, often permeate clients’ stories either directly or indirectly or are key issues in and of themselves. Jennie’s

religious sensitivities are often an important subtext in her story. Rediscovering what she really believes and values are resources for recovery. Karl, from a fundamentalist background, struggles with a religious culture he has set aside but whose elements influenced him in his tours of Iraq and Afghanistan and still play a role in his recovery. He has a lot of “musts” from his upbringing some of which help and some of which stand in the way of progress. Loyalty to church turned into loyalty to company, platoon, and squad—all with mixed feelings. The fact that he lived while some of his buddies have died leaves him with a sense of betrayal. He does not think that he has betrayed anyone or any group, but this does eradicate his sense of betrayal. So helpers need to listen carefully to the assumptions, beliefs, values, norms, ethical challenges, and moral issues and focus on what their clients see as key. Which themes emerge as important, as influential?

### **Listen to the Problem-Management Process Embedded in Whatever Treatment Model You Use**

Helpers look for signs that clients understand and can collaborate on the method of treatment. They listen for difficulties the client might have with any part of the treatment. In the case of both Jennie and Karl, the method of treatment is the problem-management process outlined in Part III. So their helpers listen to how they grasp and use the problem-management framework—telling their stories and exploring their concerns, what kind of outcomes they are looking for, and how they explore ways of achieving these outcomes. Helpers also look for clues as to clients’ level of commitment to the work involved in achieving outcomes. Neither Jennie nor Karl have any issues with the framework, though Jennie understands the language better and uses the process more proactively.

## **Identify and Deal with All Forms of Distorted Listening**

### **LO 4.6**

Listening as described here is not as easy as it sounds. Obstacles and distractions abound. Some relate to listening generally. Others relate more specifically to listening to and interpreting clients’ nonverbal behavior. The kinds of listening described in this section often (or usually) go unnoticed. In that sense, they constitute part of the shadow side of helping.

As you will see from your own experience, the following kinds of distorted listening permeate human communication. They also insinuate themselves at times into the helping dialogue. Sometimes more than one kind of distortion contaminates the helping dialogue. They are part of the shadow side because helpers never intend to engage in these kinds of listening. Rather, helpers fall into them at times without even realizing that they are doing so. But they stand in the way of the kind of open-minded listening and processing needed for real dialogue. Here are some forms of distorted listening.

**Filtered listening** It is impossible to listen to other people in a completely unbiased way. Through socialization we develop a variety of filters through



which we listen to ourselves, others, and the world around us. As Hall (1977) noted: “One of the functions of culture is to provide a highly selective screen between man and the outside world. In its many forms, culture therefore designates what we pay attention to and what we ignore. This screening provides structure for the world” (p. 85). We need filters to provide structure for ourselves as we interact with the world. But personal, familial, sociological, and cultural filters introduce various forms of bias into our listening and do so without our being aware of it.

The stronger the cultural filters, the greater the likelihood of bias. For instance, a white, middle-class helper probably tends to use white, middle-class filters in listening to others. Perhaps this makes little difference if the client is also white and middle class, but if the helper is listening to an Asian client who is well-to-do and has high social status in his community, to an African American mother from an urban ghetto, or to a poor white subsistence farmer, then the helper’s cultural filters might introduce bias. Prejudices, whether conscious or not, distort understanding. Like everyone else, helpers are tempted to pigeonhole clients because of gender, race, sexual orientation, nationality, social status, religious persuasion, political preferences, lifestyle, and the like. Helpers’ self-knowledge is essential. This includes ferreting out the biases and prejudices that distort listening.

**Evaluative listening** Most people, even when they listen attentively, listen evaluatively. That is, as they listen, they are judging what the other person is saying as good/bad, right/wrong, acceptable/unacceptable, likable/unlikable, relevant/irrelevant, and so forth. Helpers are not exempt from this universal tendency. The following interchange takes place between Jennie and a friend of hers. Jennie recounts it to Denise as part of her story.

**JENNIE:** Well, the rape and the investigation are not dead, at least not in my mind. They are not as vivid as they used to be, but they are there.

**FRIEND:** That’s the problem, isn’t it? Why don’t you do yourself a favor and forget about it? Get on with life, for God’s sake!

Evaluative listening gives way to advice giving. It might well be sound advice, but the point here is that Jennie’s friend listens and responds evaluatively. Clients should first be understood, then, if necessary, challenged or helped to challenge themselves. Evaluative listening, translated into advice giving, will just put clients off. Indeed, a judgment that a client’s point of view, once understood, needs to be expanded or transcended or that a pattern of behavior, once listened to and understood, needs to be altered can be quite useful. That is, there are productive forms of evaluative listening. It is practically impossible to suspend judgment completely. Nevertheless, it is possible to set one’s judgment aside for the time being in the interest of understanding clients, their worlds, their stories, their points of view, and their decisions “from the inside.”

**Stereotype-based listening** How would you like being referred to as the “appendicitis in 304?” Probably not much. We don’t like to be stereotyped, even

when the stereotype has some validity. The very labels we learn in our training—paranoid, neurotic, sexual disorder, borderline—can militate against empathic understanding. Books on personality theories provide us with stereotypes: “He’s a perfectionist.” We even pigeonhole ourselves: “I’m a Type A personality.” Though in this case the stereotype is often used as an excuse. “I am a Type A personality, so I can’t help what I do.”

In psychotherapy, diagnostic categories can take precedence over the clients being diagnosed. Helpers forget at times that their labels are interpretations rather than understandings of their clients. You can be “correct” in your diagnosis and still lose the person. In short, what you learn as you study psychology may help you to organize what you hear, but it may also distort your listening. To use terms borrowed from Gestalt psychology, make sure that your client remains “figure”—in the forefront of your attention—and that models and theories about clients remain “ground”—knowledge that remains in the background and is used only in the interest of understanding and helping this unique client.

***Fact-centered rather than person-centered listening*** Some helpers ask clients many informational questions, as if clients would be cured if enough facts about them were known. It’s entirely possible to collect facts but miss the person. The antidote is to listen to clients contextually, trying to focus on themes and key messages. Denise, as she listens to Jennie, picks up what is called a “pessimistic explanatory style” theme (Peterson, Seligman, & Vaillant, 1988). Clients with this style tend to say, directly or indirectly, about unfortunate events such things as “It will never go away,” “It affects everything I do,” and “It is my fault.” Denise knows that the research indicates that people who fall victim to this style tend to end up with poorer health than those who do not. There may be a link, she hypothesizes, between Jennie’s somatic complaints (headaches, gastric problems) and this explanatory style. This is a theme worth exploring.

***Sympathetic listening*** Because most clients are experiencing some kind of misery and because some have been victimized by others or by society itself, helpers tend to feel sympathy for them. Sometimes these feelings are strong enough to distort the stories that clients are telling. Consider this case.

Liz was counseling Ben, a man who had lost his wife and daughter to a tornado. Liz had recently lost her husband to cancer. As Ben talked about his own tragedy during their first meeting, she wanted to hold him. Later that day she took a long walk and realized how her sympathy for Ben had distorted what she heard. She heard the depth of his loss, but, reminded of her own loss, only half heard the implication that his loss now excused him from getting on with his life.

Sympathy has an unmistakable place in human relationships, but its “use,” if that does not sound too inhuman, is limited in helping. In a sense, when I sympathize with someone, I become his or her accomplice. If I sympathize with my client as she tells me how awful her husband is, I take sides without knowing what the complete story is. Expressing sympathy can reinforce self-pity, which has a way of driving out problem-managing action.

***Falling for myths about nonverbal behavior*** Richmond and McCroskey (2000) spell out the shadow side of nonverbal behavior in terms of commonly held myths (pp. 2–3):

1. *Nonverbal communication is nonsense. All communication involves language. Therefore, all communication is verbal.* This myth is disappearing. It does not stand up under the scrutiny of common sense.
2. *Nonverbal behavior accounts for most of the communication in human interaction.* Early studies tried to “prove” this, but they were biased. Studies were aimed at dispelling myth number 1 and overstepped their boundaries.
3. *You can read a person like a book.* Some people, even some professionals, would like to think so. You can read nonverbal behavior, verbal behavior, and context and still be wrong.
4. *If a person does not look you in the eye while talking to you, he or she is not telling the truth.* Tell this to liars! The same nonverbal behavior can mean many different things.
5. *Although nonverbal behavior differs from person to person, most nonverbal behaviors are natural to all people.* Cross-cultural studies give the lie to this. But it isn’t true even within the same culture.
6. *Nonverbal behavior stimulates the same meaning in different situations.* Too often the context is the key. Yet some professionals buy the myth and base interpretive systems on it.

***Interrupting*** I am reluctant to add “interrupting,” as some do, to this list of shadow-side obstacles to effective listening. Certainly, when helpers interrupt their clients, by definition, they stop listening. And interrupters often say things that they have been rehearsing, which means that they have been only partially listening. Our reluctance, however, comes from the conviction that the helping conversation should be a dialogue. There are benign and malignant forms of interrupting. The helper who cuts the client off in mid thought because he has something important to say is using a malignant form. But the case is different when a helper “interrupts” a monologue with some gentle gesture and a comment such as “You’ve made several points. I want to make sure that I’ve understood them.” If interrupting promotes the kind of dialogue that serves the problem-management process, then it is useful. Still, care must be taken to factor in cultural differences in storytelling.

One possible reason counselors fall prey to these kinds of shadow-side listening is the unexamined assumption that listening with an open mind is the same as approving what the client is saying. This is not the case, of course. Rather, listening with an open mind helps you learn and understand. Whatever the reason for shadow-side listening, the outcome can be devastating because of a truth philosophers learned long ago—a small error in the beginning can lead to huge errors down the road. If the foundation of a building is out of kilter, it is hard to notice with the naked eye. But by the time construction reaches the ninth floor, it begins to look like the leaning tower of Pisa. Tuning in to clients and listening both actively and with an open mind are foundation counseling skills. Ignore them and dialogue is impossible.

# Empathic Responding: Work at Mutual Understanding

## LEARNING OBJECTIVES

- 5.1 Understand the Importance of Responding Skills in Developing Relationships with Clients**
  - Respond Skillfully to What Clients Say Verbally and Nonverbally
  - Use Empathy as a Communication Skill to Develop Your Relationships
  - Take a Wide View of Empathy as a Communication Skill
- 5.2 Become Adept in the Three Dimensions of All Responding Skills: Perceptiveness, Know-How, and Assertiveness**
  - Develop Perceptiveness as the Foundation of Responding Skills
  - Learn the Basic Know-How of Responding Well
  - Be Assertive in Responding to Clients
- 5.3 Become Competent in the Know-How of Communicating Empathy**
  - Start with the Basic Formula for Communicating Empathy
  - Respond Accurately to Clients' Feelings, Emotions, and Moods
  - Respond Accurately to the Key Experiences, Thoughts, and Behaviors in Clients' Stories
  - Adopt Useful Tactics for Responding with Empathy
  - Respond Selectively to Core Client Messages
  - Respond to the Context, Not Just to the Words
  - Learn How to Recover from Inaccurate Understanding
- 5.4 Use Empathy Wisely to Achieve a Number of Therapeutic Goals**
  - Use Empathy throughout the Helping Process
  - Use Empathic Responses as a Mild Social-Influence Process
  - Use Empathic Responses as a Way of Bridging Diversity Gaps
- 5.5 Review the Case of Alex, the Client, and Doug, the Helper**
- 5.6 Explore the Shadow Side of Responding**

## Understand the Importance of Responding Skills in Developing Relationships with Clients **LO 5.1**

Helpers listen to clients both to understand them and their concerns and to respond to them in constructive ways. The logic of listening includes, as we have seen, tuning in to clients both physically and psychologically; listening actively; processing what is heard contextually; and identifying the key ideas, messages, or points of view the client is trying to communicate—all in the service of understanding clients and helping them understand themselves. Listening, then, is a very active process that is at the heart of understanding.

### Respond Skillfully to What Clients Say Verbally and Nonverbally

Helpers do not just listen; they also respond to clients in a variety of ways. They respond by sharing their understanding, checking to make sure that they have gotten things right, probing for clarity, summarizing the issues being discussed, and helping clients challenge themselves in a variety of ways. Of course, this is not a one-way street. Helpers respond to clients and clients respond to helpers in the give-and-take of the therapeutic dialogue.

The value of inclusive empathy (Clark, 2003; Elliott, Bohart, Watson, & Greenberg, 2011; Pedersen et al., 2008;) and the other values discussed in Chapter 3 should permeate all responses to clients. Counselors use the responding skills of empathy, probing, summarizing, and facilitating client self-challenge described in Part II, Chapters 4–7 not only to help clients tell and explore their stories but also in every stage and task of the problem-management framework covered in Part III. That is, helpers use all the communications skills outlined in Part II to help clients explore possibilities for a better future, set goals, develop plans for achieving goals, and turn all this planning into problem-managing and opportunity-developing action.

We said earlier that the communication skills in helping situations are not special therapeutic skills. Rather they are skills that should characterize everyday interactions of ordinary people, even though, unfortunately, this is not the case. The ability to express empathy, the topic of this chapter, is important because we all want to be understood and we function better when we are understood. In day-to-day conversations, responding with empathy is also a tool of civility. Making an effort to get in touch with your conversational partner's frame of reference sends a message of respect. Therefore, empathic responses play an important part in building relationships.

### Use Empathy as a Communication Skill to Develop Your Relationships

In everyday life, understanding does not necessarily have to be put into words. People establish empathic relationships with one another in which understanding is communicated in a variety of rich and subtle ways without necessarily being put into words when given enough time. A simple glance across a room as one spouse sees the other trapped in a conversation with a person he or she does not want to be with can communicate worlds of understanding. The glance says, "I know you feel caught. I know you don't want to hurt the other person's feelings. I can feel the struggles going on inside you. But I also know that you'd

like me to rescue you as soon as I can do so tactfully.” The signaling discussed in Chapter 4 plays an important role in the communication of empathy.

People with empathic relationships often express empathy in actions. An arm around the shoulders of someone who has just suffered a defeat expresses both empathy and support. Pam, a retired economics professor, excitedly ran for a seat on her local city council but lost in a close race. Her husband, Rory, knowing she would be disappointed, rounded up friends, their children and grandchildren, and even some colleagues and former students to greet her when she got home. She was welcomed to a large ovation and a banner strewn across their front porch that said “We Are Proud of You Pam!” Rory was there to give her a big hug and say, “We will get ‘em next time.” The blow she received was lightened.

On the other hand, some people enter caringly into the world of their relatives, friends, and colleagues and are certainly “with” them but do not know how to communicate understanding through words or feel the need to do so. When a wife complains, “I don’t know whether he really understands,” she is not necessarily saying that their relationship is not mutually empathic. She is more likely saying that she would appreciate it if he were to put his understanding into words from time to time in order to *feel* understood.

The therapeutic alliance should be an empathic relationship. The skill and practice of communicating empathy to clients should not be a means to an end, but rather should be an integral part of the therapeutic relationship that is found throughout the helping process. What Pedersen and his associates (2008) call “**inclusive cultural empathy**” mentioned in Chapter 3 should permeate every facet of the dialogue between helper and client. This is not heroic but human. The “technology” of communicating empathy outlined in this chapter is humanized through the relationship. Empathy is a two-way street (Messina, Palmieri, Sambin, Kleinbub, Voci, & Calvo, 2013). Clients must be willing to reveal themselves and helpers must be ready to understand. Here is another way of looking at the fullness of empathy. At one level there is, ideally, a verbal dialogue as described earlier between client and helper. But at another level, there should also be an ongoing *social-emotional* dialogue between helper and client. This makes the relationship real and genuine. Goleman and Boyatzis (2008) in an article on social intelligence and the biology of leadership put it this way:

The salient discovery is that certain things leaders do—specifically, exhibit empathy and become attuned to others’ moods—literally affect both their own brain chemistry and that of their followers. Indeed, researchers have found that the leader-follower dynamic is not a case of two (or more) independent brains reacting consciously or unconsciously to each other. Rather, the individual minds become, in a sense, fused into a single system (p. 76).

Both the Goleman and Boyatzis and the Messina and colleagues articles use neuroscience to flesh out our understanding of empathy. In some non-hokey sense my being is communing with yours and yours with mine when we engage in empathic dialogue. This affects the quality and substance of the words we use. While it is possible to learn the skill and technology of responding with empathy, the exercise of that skill is hollow outside a genuine and caring relationship. The process of communicating empathy as described in this chapter must be seen through this lens.

## Take a Wide View of Empathy as a Communication Skill

Empathy, we are told, is back in favor in academic circles (Bayne & Hayes, 2017; Elliott et al., 2011; Stueber, 2010; Watson et al., 2014). Hopefully in the helping professions it has never been out of favor. Some now see empathy not just as a value and skill, but also as a mode of treatment in itself (Slattery & Park, 2011). Empathic responding, in the view taken in this book, is based on empathic listening and involves sharing with clients your nonjudgmental understanding of what they are thinking and feeling. Rogers (1980) described empathy in this way (as quoted in Elliott et al., p. 133). Empathy is

the therapist's sensitive ability and willingness to understand the client's thoughts, feelings, and struggles from the client's point of view. [It is] this ability to see completely through the client's eyes, adopt his frame of reference . . . (p. 85) . . . It means entering the private perceptual world of the other . . . being sensitive, moment by moment, to the changing felt meanings which flow in this other person . . . It means sensing meanings of which he or she is scarcely aware. . . . (p. 142)

We will revisit Rogers' last sentence in Chapter 6 when we talk about helping clients get in touch with these "meanings." That said, empathy is not an interpretation, but is derived from the client's frame of reference. You may initially believe that a person's struggle with depression is, based on your logic, related to being unemployed. It may or may not be that simple. Rushing in to provide your reasoning belies the process of being empathic. Empathy signals your desire to understand how clients see themselves, others, and the world. It is a way of checking the accuracy of the listening and thoughtful processing mentioned in the previous chapter. It also signals your wish to put clients first and collaborate with them in their efforts to manage the problem situations of their lives. In short, empathy is critical to the helping process. Norcross (2010) puts it this way: "Empathy is linked to outcomes because it serves a positive relationship function, facilitates a corrective emotional experience, promotes exploration and meaning creation, and supports clients' self-healing" (p. 119).

Arthur Clark (2007) devotes an entire book to empathy in counseling and therapy. In Part 2 of his book, he outlines the important role empathy plays in 13 different methods of treatment. He has also come up with a wider view of empathy (2010a) that possibly affects the purism of the concept outlined above. He describes three kinds of empathy: subjective, interpersonal, and objective. In his view, **subjective empathy** "enables a counselor to momentarily identify with a client through intuitive reactions and fleetingly imagine and experience what it is like to be a client" (p. 349). This kind of understanding of the client comes from the understanding of oneself and one's exposure, in reality or in imagination, to experiences similar to those of the client. When a client discusses an issue, such as struggling with perfectionism, the helper briefly recalls his own struggle. The counselor is not necessarily distracted by what he or she experiences. Rather it adds something to his or her understanding of the client. **Objective empathy** arises from what a counselor has learned from various sources, including his own experience or from reputable theories and research findings. As Rema, a counselor, listens to Benjamin's story, she begins to see the outline of an obsessive-compulsive disorder. This, tentatively, adds to her understanding of Benjamin.



Both subjective and objective empathy provide the counselor with some kind of understanding of the client, but it is usually not the kind of understanding that is shared either immediately or directly with the client. Rema is hardly going to say, “Ah-ha, a classic case of obsessive-compulsive disorder!”

The kind of empathy described and illustrated in this chapter is *interpersonal empathy*, the ability to get inside a client’s frame of reference and understand what the client is thinking and feeling together with the ability to communicate this understanding without prejudice to the client. If the client feels understood, he or she is more likely to “move forward” in the helping process in a number of ways. It can lead to such outcomes as the strengthening of the therapeutic alliance, a deeper understanding of self, a better grasp of the problem situation, and a clearer idea of what the desired outcome of the problem-management process should be. That said, both subjective and objective empathy could either contribute to and facilitate interpersonal empathy or, conversely, stand in the way. When a counselor, let’s say Jeff, is personally struck by what Susan is saying, this can help him get inside Susan’s frame of reference or cause him to be distracted from her story. When Clarissa realizes that Ted’s story fits in with the findings of a research project she is conducting, this, too, can complement what Ted is saying about himself.

Consider this example. A counselor, Sacha, has his first meeting with a client, Mariah, who has just lost her husband. He had a heart attack while driving and either the heart attack or the crash killed him. She has two teenage sons. The meeting takes place about a week after the funeral. Here is part of their conversation.

**SACHA:** First of all, I’d like to express my sorrow for your loss. So sudden. I lost my wife like that three years ago.

**MARIAH (pauses):** My loss. Well . . . (she says this very softly, pauses, and then sitting up straight, she leans forward and continues in a stronger voice). Tragic? Of course. His loss? Yes. But it wouldn’t be right to call it my loss. The last years have not been very nice.

**SACHA:** The two of you were not getting along . . . at all.

**MARIAH:** At all . . . I don’t know when our marriage died. I’m sure he blamed me. But for the last three years he has been going out with other women. Gambling. There’s no use going into all of it. He still supported us, financially, that is. It’s been a nightmare, but it’s over. Fate intervened.

**SACHA:** You’re relieved. . . . Maybe more than relieved?

**MARIAH:** I am totally relieved. But just saying it straight out like that makes me feel . . . What’s the word I’m looking for?

**SACHA:** Sounds like you don’t want to say “guilty.”

**MARIAH:** No I don’t . . . I’m more than relieved. I’m free. There’s something like hope in the air. I still feel that I’m trampling on his grave . . . No, that’s not it.

**SACHA:** Well, you are free to reconstruct your life. Perhaps the hope part means that’s what you want to do.

**MARIAH:** That’s just what I want to do. There’s a lot of hard work ahead of me.

Sacha makes two mistakes. One relates to objective empathy. He reverts to the “grieving widow” stereotype in his first statement. The other relates to subjective empathy, also in his first statement. He compares her loss to his. Catching himself, he takes his mind off himself and listens intently to what she has to say. She responds to his brief empathic responses by telling her story, expressing emotions that *she* feels, and looking toward the future.

This hardly means that subjective and objective empathy are always out of order. Rather they should be complementary to interpersonal empathy, not central. The literature on empathy is infuriatingly rich. There is no such thing as one pure approach to empathy. The approach taken in this chapter is based primarily on having the needs of the client drive the helping process. If we remember that clients and their concerns are of primary importance, we can learn to instinctively relate elements of both subjective and objective empathy to the kind of interpersonal empathy that immediately serves the needs of the client. Or we can let our own experiences together with the theories and research findings of our profession distract us from what the clients needs. But that would not be professional. This chapter highlights the importance of empathy but keeps the focus on the client. Again, the power of the basics.

## Become Adept in the Three Dimensions of All Responding Skills: Perceptiveness, Know-How, and Assertiveness **LO 5.2**

Before we begin our exploration of empathy as a communication skill, here is a caution that applies to this and to the rest of the chapters of this book. There will be a kind of anatomy lesson in each chapter. For instance, in this chapter we are going to take the process of responding with empathy apart and look at the pieces. There will also be anatomy lessons in probing, summarizing, facilitating client self-challenge, goal setting, action-plan design, and implementation. The purpose of the anatomy lesson is to give you a deeper understanding of the processes involved in helping. Of course, the parts will be reassembled to give you a feeling for the skill-in-action. This process of breaking a skill down into its component parts is hardly restricted to counseling. People do this in learning how to fix an automobile engine, design a dress, swing a golf club, analyze a company's balance sheets, give a talk, or get in touch with fundamental particles that make up the universe. Learning bit-by-bit is not always “fun,” but it is often the price to pay for competence.

The communication skills involved in responding to clients have three dimensions: perceptiveness, know-how, and assertiveness. Although empathy is an extremely important responding skill, it is not the only one. Helpers respond to clients by asking questions, providing information, asking for help to understand the points clients are making, providing examples, inviting clients to challenge themselves—and the list goes on. Perceptiveness, know-how, and assertiveness are essential for all forms of responding. In this section, however, we focus mostly on responding with empathy.

## Develop Perceptiveness as the Foundation of Responding Skills

Know what is going on. “Feeling empathy” for others is not helpful if the helper’s perceptions are not accurate. Indeed, empathy in terms of feeling what other people are feeling—anger, anxiety, desperation, horror, lonely, pain of any kind—can, according to some (Bloom, 2016, 2017), be harmful. But empathy, as used here, is much more than a feeling for the other person; therefore, accuracy is more complicated than one would first think. Ickes (1993, 1997; Mast & Ickes, 2007) defined “**empathic accuracy**” as “the ability to accurately infer the specific content of another person’s thought and feelings” (1993, p. 588). According to Ickes, this ability is a component of success in many walks of life.

Empathically accurate perceivers are those who are consistently good at “reading” other people’s thoughts and feelings. All else being equal, they are likely to be the most tactful advisors, the most diplomatic officials, the most effective negotiators, the most electable politicians, the most productive salespersons, the most successful teachers, and the most insightful therapists. (Ickes, 1997, p. 2)

The assumption is, of course, that such people are not only accurate perceivers but they can also weave their perceptions into their dialogues with their constituents, customers, students, and clients. Helpers do this by sharing empathic responses with their clients. An empathic response involves accurately communicating one’s understanding of another person from that person’s point of view. Clinically, however, it is accurate only if it is perceived to be accurate by the client (Hodges, 2005; Reese et al., 2016). The understanding, the communication of that understanding, and the client’s view of the accuracy are all components. Accuracy is a relationship thing that is subject to all the uncertainties involved in the relationship.

From one point of view, your responding skills are only as good as the accuracy of the perceptions on which they are based. Consider the difference between these two examples.

Beth is counseling Ivan in a community mental health center. Ivan is scared to talk about an “ethical blunder” that he made at work. Beth senses his discomfort but thinks that he is angry rather than scared. She says, “Ivan, I’m wondering what’s making you so angry right now.” Because Ivan does not feel angry at the moment, he says nothing. In fact, he’s startled by what she says and feels even more insecure. Beth takes his silence as a confirmation of his “anger.” She tries to get him to talk about it.

Beth’s perception is wrong; and therefore, disrupts the helping process. She misreads Ivan’s emotional state and tries to engage in a dialogue based on her flawed perception. Contrast this to what happens in the following example.

Tomas is a Latino male and a new accountant in a medium-sized accounting firm. He reluctantly seeks the counsel of his assigned mentor, Zoe, a senior partner in the accounting firm, because he feels overwhelmed and stressed as a new professional in the firm. He is thinking of quitting. Zoe knows that feeling overwhelmed is not uncommon for new accountants in the firm, but she is careful not to assume how Tomas feels or to provide such clichés such as “it will get better” or to convince him to stay. Instead, Zoe listens to Tomas’ story. She notices that as Tomas shares his concerns of feeling overwhelmed and not feeling good enough, he also noted feeling

more than uncomfortable when the office hosted a Cinco de Mayo party and several people dressed in fake sombreros and mustaches. Zoe knew he had performed well and that his concerns seemed to be about feeling uncomfortable, and at times unwelcomed, as a Latino, the only Latino, in the firm. Zoe, who is White, engages in active listening and after working to understand his story said, “Being a new accountant here is tough enough, but it also seems like you have to deal with the added stress of feeling a bit like an outsider, especially with the cultural appropriation you witnessed with Cinco de Mayo.” Tomas quickly says, “Exactly! I feel like an outsider even though people have treated me well, but it still seems like I am not accepted in the same way as my White colleagues who are new.” This opened the door for Tomas to share how he felt and to discuss how the firm could create a more positive work environment for professionals of color.

Zoe’s perceptiveness and her ability to listen carefully and be culturally responsive helped her firm to retain an excellent young accountant and lay the groundwork for the firm to provide a better, more inclusive work environment.

The kind of perceptiveness that is required in order to be a good helper comes from basic intelligence, social intelligence, experience, reflecting on your experience, developing wisdom, and, more immediately, tuning in to clients, listening carefully to what they have to say, and thoughtfully and objectively processing what they say. Perceptiveness is part of social-emotional maturity. Finally, empathic accuracy is important, but it is not a thing in itself. Rather it is something you do *with* the client. The *effort* to be accurate may not always lead to perfect accuracy but it can lead to a collaborative discussion with the client that produces the kind of shared understanding, which, in turn, helps the client move forward.

## Learn the Basic Know-How of Responding Well

Once you are aware of what kind of response is called for, you need to be able to deliver it. For instance, if you are aware that a client is anxious and confused because this is his first visit to a helper, it does little good if you do not know how to translate your perceptions and your understanding into words. Let’s return to Ivan and Beth for a moment.

Ivan and Beth end up arguing about his “anger.” Ivan finally gets up and leaves. Beth, unfortunately, takes this as a sign that she was right in the first place. The next day Ivan goes to see his minister. The minister sees quite clearly that Ivan is scared and confused. His perceptions are right. He says something like this: “Ivan, you seem to be very uncomfortable. It may be that whatever is on your mind might be difficult to talk about. But I’d be glad to listen to it, whatever it is. But I don’t want to push you into anything.” Ivan blurts out, “But I’ve done something terrible.” The minister pauses and then says, “Well, let’s see what kind of sense we can make of it.” Ivan hesitates a bit, then leans back into his chair, takes a deep breath, and launches into his story.

The minister is not only perceptive but also knows how to address Ivan’s anxiety and hesitation. It is as if the minister says to himself, “Here’s a man who is almost exploding with the need to tell his story, but fear or shame or something like that is paralyzing him. How can I put him at ease, let him know that he won’t get hurt here? I need to recognize his anxiety and offer an opening.” He does not use these words, of course, but these are the kind of sentiments that instinctively run

through his mind. This chapter is designed to help you develop the know-how needed to communicate accurate empathic understanding.

### Be Assertive in Responding to Clients

Accurate perceptions and excellent know-how are meaningless if they remain locked up inside you. They need to become part of the therapeutic dialogue. For instance, if you see that self-doubt is a theme that weaves itself through a client's story about her frustrating search for a better relationship with her estranged brother but fail to share your hunch with her, you do not pass the assertiveness test. Consider this example.

Whitney is a new student at a middle school after moving because her mother was transferred for her job. She is a great student who was initially excited about a new adventure, but became the target of bullying after a group of students saw her high test grades and noticed that she was placed in the Gifted and Talented Program at the school. Whitney's grades, especially on her tests, dramatically dropped. She was referred for counseling to work on "test anxiety." Howard, an intern counselor, tried to help her formulate a well-organized and thorough plan using cognitive-behavioral strategies to deal with upcoming tests. Whitney, however, does not seem engaged in the relaxation and study strategies and passively participates. Howard suspects that something else is going on—she has never had trouble on tests before and seems evasive and uncomfortable when talking about her relationships at school. Howard rightfully believes there is trouble on the peer front. Whitney, fearful of retribution if she tells a school official, is reluctant to share what is going on. At the end of their third session, Howard asks for feedback from Whitney about how she thinks the sessions are going. He hopes she takes the offer to talk about how what is really going on with her. Whitney simply says, "Ummm . . . okay I guess." Although Howard has a strong hunch this was not accurate he ultimately responds, "Well, if something is not okay I hope you know you can tell me." As a result, Whitney will continue to be victimized and suffer in silence; and ultimately decide that she does not need to go to counseling anymore.

In this case, perceptiveness and know-how were present. Howard observed that something was amiss in the sessions. Whitney avoided talking about her social life at school (typically of great importance in a middle school student's life). He also demonstrated know-how by following this hunch and soliciting feedback to discuss the source of her lack of engagement in the sessions. Howard, however, lacked the assertiveness in this situation to share his perception of what seemed amiss. This is not to suggest that assertiveness is an overriding value in and of itself. To be assertive without perceptiveness and know-how is to court disaster. You have to be thoughtful and pick your spots. These three dimensions of responding skills apply to all the communication skills discussed in Part II and their use in all the stages and tasks of the problem-management helping process.

## Become Competent in the Know-How of Communicating Empathy

LO 5.3

Although many people may "feel empathy" for others—that is, are motivated in many different ways by the value of empathy described in Chapter 2—the truth is that few know how to put empathic understanding into words. And so responding

with empathy as a way of communicating understanding during conversations remains, unfortunately, a relatively improbable event in everyday life. Perhaps that is why it is so powerful in helping settings. When clients are asked what they find helpful in counseling sessions, being understood gets top ratings (Swan & Heesacker, 2013; Swift & Callahan, 2010), in part because so many of them have an unfulfilled need to be understood. They do not find it in their everyday life.

### Start with the Basic Formula for Communicating Empathy

Some say that trying to teach counselors how to respond with empathy is “rigid and wooden.” I believe that empathy can be taught, but all communication skills come to life, are personalized, and become part of one’s interpersonal relationship style only through genuine day-to-day use. The communication of basic empathic understanding can be expressed in the following stylized formula:

*You feel . . . [here name the correct emotion expressed by the client]  
because . . . [here indicate the correct experiences, thoughts, and behaviors that  
give rise to the feelings].*

For instance, Kenny is talking with a helper about his arthritis and all its attendant ills. There is pain, of course, but more to the point, he cannot get around the way he used to. At one point the helper says:

“You feel bad, not so much because of the pain, but because your ability to get around—your freedom—has been curtailed.”

Kenny replies:

“That’s just it! I can manage the pain. But not being able to get around is killing me! It’s like being in jail.”

They go on to discuss ways in which Kenny, with the help of family and friends, can get out of “jail” more often—that is, become more mobile—together with ways of coping with both the pain and the boredom of his “jail” time.

The formula—“You feel . . . because . . .”—is a beginner’s tool to get used to the concept of responding with accurate empathy. It focuses on the key points of clients’ stories, points of view, intentions, proposals, and decisions together with the feelings, emotions, and moods associated with them. The formula is used in the following examples. For the moment, ignore the fact that it might sound a bit stylized. Ordinary human language will be substituted later. In the first example, a divorced mother with two young children is talking to a social worker about her ex-husband. She has been talking about the ways he has let her and their kids down. She ends by saying:

**CLIENT:** I could kill him! He failed to take the kids again last weekend. This is three times out of the last 6 weeks.

**HELPER:** You feel furious because he keeps failing to hold up his part of the bargain.

**CLIENT:** I’m not even sure that he’s taking our “bargain” seriously. I just have to find some way to get him to do what he promised to do. What he told the court he would do.

His not taking the kids according to their agreement [an experience for the client] infuriates her [an emotion]. The helper captures both the emotion and the reason for it. And the client moves forward in terms of thinking about possible actions she could take.

In the next example, a woman who has been having a great deal of gastric and intestinal distress is going to have a colonoscopy. She is talking with a hospital counselor the night before the procedure.

**PATIENT:** God knows what they'll find when they go in. I keep asking questions, but they keep giving me vague answers.

**HELPER:** You feel troubled because you believe that you're being left in the dark.

**PATIENT:** In the dark not just about my body. It's my life! If they'd only tell me! Then I could prepare myself better.

They go on to discuss what she needs to do to get the kind of information she wants. The accuracy of the helper's response does not solve the woman's problems, but the patient does move a bit. She gets a chance to vent her concerns. Once she feels understood, she says why she wants more information. This perhaps puts her in a better position to ask for a more open relationship with her doctors.

### **Respond Accurately to Clients' Feelings, Emotions, and Moods**

In keeping with the basic formula, "You feel . . . because," let's start with emotions. The importance of feelings, emotions, and moods in our lives was discussed in Chapter 4. Helpers need to respond to clients' emotions in such a way as to move the helping process forward. This means identifying key emotions the client either expresses or discusses (helper perceptiveness) and weaving them into the dialogue (helper know-how) even when they are sensitive or part of a messy situation (helper courage or assertiveness). Do you remember the last time you, as a consumer, got a problem resolved with a good customer service representative? She might have said something like this to you: "I know you're angry right now because the package didn't arrive and you have every right to be. After all, we did make you a promise. Here's what we can do to make it right for you. . . ." Rather than ignoring the customer's emotions, good customer service reps face up to them as helpfully as possible. Here are some guidelines:

***In responding, use the right family of emotions and the right intensity*** In the basic empathy formula, "You feel . . ." should be followed by the correct family of emotions and the correct intensity.

*Family.* The statements "You feel hurt," "You feel relieved," and "You feel enthusiastic," specify different families of emotion.

*Intensity.* The statements "You feel annoyed," "You feel angry," and "You're furious" specify different degrees of intensity in the same family (anger).

The words sad, mad, bad, and glad refer to four of the main families of emotion, whereas content, quite happy, and overjoyed refer to different intensities within the glad family.



***Distinguish between expressed and discussed feelings*** Clients both express emotions they are feeling during the interview and talk about emotions they felt at the time of some incident. Consider the exchange below between an adolescent client whose mother died of cancer 8 months ago and his counselor.

**CLIENT (with little emotion):** I don't know, I usually feel down when I get home from school; my mom was usually home then.

**HELPER:** You feel especially sad then because it is a powerful reminder of your relationship with your mom.

The client is not particularly sad right now. Rather, he is talking about when he feels most sad. Now consider how the following example—a woman is talking about one of her colleagues at work—deals with expressed rather than discussed feelings.

**CLIENT (enthusiastically):** I threw caution to the wind and confronted him about his sarcasm and it actually worked. He not only apologized but also behaved himself for the rest of the trip.

**HELPER:** You feel great because you took a chance and it paid off.

Clients do not always name their feelings and emotions. However, if they express emotion, it is part of the message and needs to be identified and understood.

***Read and respond to feelings and emotions embedded in clients' nonverbal behavior*** Often helpers have to read clients' emotions—both the family and the intensity—in their nonverbal behavior. In the following example, a North American student comes to you, sits down, looks at the floor, hunches over, and speaks haltingly:

**CLIENT:** I don't even know where to start. (He falls silent).

**HELPER:** It's pretty clear that you're feeling miserable. Maybe we can talk about why.

**CLIENT (after a pause):** Well, let me tell you what happened . . .

You see that he is depressed and his nonverbal behavior indicates that the feelings are quite intense. His nonverbal behavior reveals the broad family ("You feel bad") and the intensity ("You feel very bad"). Of course, you do not yet know the experiences, thoughts, and behaviors that give rise to these emotions.

***Be sensitive in naming emotions*** Naming and discussing feelings and emotions threaten some clients. Cultural sensitivities and personal sensitivities within a culture differ widely. If this is the case, it might be better to focus on experiences, thoughts, and behaviors and proceed only gradually to a discussion of feelings. The following client, a single man in his mid-30s who has come to talk about "certain dissatisfactions" in his life, has shown some reluctance to express or even to talk about feelings.

**CLIENT (in a pleasant, relaxed voice):** You won't believe it! My mother is always trying to make a little kid out of me. And I'm 35! Last week, in front of a group of my friends, she brought out my rubber boots and an umbrella and gave me a little talk on how to dress for bad weather (laughs).

**COUNSELOR A:** It might be hard to admit it, but I get the feeling that down deep you were furious.

**CLIENT:** Well, I don't know about that. Anyway, at work. . . .

Counselor A pushes the emotion issue and is met with some resistance. The client changes the topic.

**COUNSELOR B (in a somewhat lighthearted way):** So she's still playing the mother role—to the hilt, it would seem.

**CLIENT (with more of a bite in his voice):** And the hilt includes not wanting me to grow up. But I am grown up . . . well, pretty grown up. But I don't always act grown up around her.

Counselor B, choosing to respond to the "strong mother" issue rather than the more sensitive "being kept a kid and feeling really lousy about it" issue, gives the client more room to move. This works, for the client himself moves toward the more sensitive issue—his playing the child, at least at times, when he is with his mother.

Some clients are hesitant to talk about certain emotions. One client might find it relatively easy to talk about his anger but not his hurt. The following client is talking about his disappointment at not being chosen for a special team at work.

**CLIENT:** I worked as hard as anyone else to get the project up and running.

In fact, I was at the meeting where we came up with the idea in the first place. . . . And now they've dropped me.

**COUNSELOR A:** So you feel really hurt—left out of your own project.

**CLIENT (hesitating):** Hmm. . . . I'm really ticked off. Why shouldn't I be? . . .

Here is a client with a lot of ego. He does not like the idea that he has been "hurt." Counselor B takes a different tack.

**COUNSELOR B:** So it's more than annoying to be left out of what, in many ways, is your own project.

**CLIENT:** How could they do that? . . . It is more than annoying. It's . . . well . . . humiliating!

Counselor B, factoring in the client's ego, sticks to the anger, allowing the client himself to name the more sensitive emotion. Contextual listening—in this case listening to the client's emotions through the context of the pride he takes in himself, his accomplishments, and their relationships at work that have gone wrong—is part of social intelligence. However, being sensitive to clients' sensitive emotions should not rob counseling of its robustness. Too much tiptoeing around clients' "sensitivities" does not serve them well. Remember what was said earlier. Clients are not as fragile as we sometimes make them out to be.

**Use variety in responding to clients' feelings and emotions** Because clients express feelings in a number of different ways, helpers can communicate an understanding of feelings in a variety of ways.

*By single words.* You feel good. You are depressed. You feel abandoned. You are delighted. You feel trapped. You are angry.

*By different kinds of phrases.* You are sitting on top of the world. You feel down in the dumps. You feel left in the lurch. Your back is up against the wall. You are really on a roll.

*By what is implied in behavioral statements.* You feel like giving up (implied emotion: despair). You feel like hugging him (implied emotion: joy). Now that you see what he has been doing to you, you almost feel like throwing up (implied emotion: disgust).

*By what is implied in experiences the client is discussing.* You feel you are being dumped on (implied feeling: victimized). You feel you are being stereotyped (implied feeling: resentment). You feel you are at the top of her list (implied feeling: elation). You feel you are going to get caught (implied feeling: fear). Note that the implication of each could be spelled out: You feel angry because you are being dumped on. You resent the fact that you are being stereotyped. You feel great because it seems that you are at the top of her list.

Because ultimately you must discard formulas and use your own language—words that are yours rather than words from a textbook and words that make sense to the client—it helps to develop a variety of ways of communicating your understanding of clients' feelings and emotions. It keeps you from being wooden in your responses.

Consider this example: The client tells you that she has just been given the kind of job she has been looking for over the past 2 years. Here are some possible responses to her emotion.

*Single word.* You're really happy.

*A phrase.* You're on cloud nine.

*Experiential statement.* You feel you finally got what you deserve.

*Behavioral statement.* You feel like going out and celebrating.

With experience, you can extend your range of expression at the service of your clients. Providing variety will become second nature.

### **Neither overemphasize nor underemphasize feelings, emotions, and moods**

Some counselors take an overly rational approach to helping and almost ignore clients' feelings. Others become too preoccupied with clients' emotions and moods. They pepper clients with questions about feelings and at times extort answers. To say that feelings, emotions, and moods are important is not to say that they are everything. The best defense against either extreme is to link feelings, emotions, and moods to the experiences, thoughts, and behaviors that give rise to them.

### **Respond Accurately to the Key Experiences, Thoughts, and Behaviors in Clients' Stories**

Key experiences, thoughts, and behaviors give rise to clients' feelings, emotions, and moods. Of course, they are important parts of clients' stories in themselves. Remember: helpers must work at understanding clients through their experiences,

thoughts, behaviors, emotions, feeling, and moods. The “because . . .” in the empathic-response formula links all of these elements together. In the following example, the client, a graduate student in law school, is venting his frustration.

**CLIENT (*heatedly*):** You know why he got an A? He took my notes and disappeared. I didn’t get a chance to study them. And I never even confronted him about it.

**HELPER:** You feel doubly angry because not only did he steal your notes, but also you let him get away with it.

The response specifies both the client’s experience (the theft) and his behavior (in this case, a failure to act) that give rise to his distress. His anger is directed not only at his classmate but also himself.

In the following example, a man who was assaulted and robbed has been talking to a social worker to help cope with his fears of going out. Before the assault, he had never worried about being unsafe in the city. Now he sees danger everywhere.

**CLIENT:** This gradual approach of getting back in the swing of things seems to be working. Last night I went out without someone going with me. First time. I have to admit that I was scared. But I think I’ve learned how to be careful. Last night was important. I feel I can begin to move around again.

**HELPER:** You feel comfortable with the one-step-at-a-time approach you’ve been taking. And it paid off last night when you regained a big chunk of your freedom.

**CLIENT:** That’s it! I know I’m going to be free again. . . . Here’s what I’ve been thinking of doing. . . .

The client is talking about success in implementing a course of action. The helper’s response recognizes the client’s satisfaction and also how important it is for the client to feel both safe and free. As observed, empathy is not simply repeating or rephrasing what has been said. Empathy provided understanding and clarity, a form of support that can reinforce emotions and behaviors, which can help clients move on. In this example, the client moves on to describe the next phase of his program. He is moving forward.

Another client, after a few sessions spread out over 6 months, says something like this about the progress she is making in rebuilding her life after a devastating car accident. She is back at work and has been working with her partner at rebuilding their relationship.

**CLIENT (*talking in an animated way*):** I really think that things couldn’t be going better. I’m doing very well at my new job, and Thomas isn’t just putting up with it. He thinks it’s great. He and I are getting along better than ever, even sexually, and I never expected that. We’re both working at our relationship. I guess I’m just waiting for the bubble to burst.

**HELPER:** You feel great because things have been going better than you ever expected—and it seems almost too good to be true.

**CLIENT:** Well, a “bubble bursting” might be the wrong image. I think there’s a difference between being cautious and waiting for disaster to strike. I’ll always be cautious, but I’m finding out that I can make things come true instead of sitting around waiting for them to happen as I usually do. I guess I’ve got to keep making my own luck.

This client talks about her experiences, attitudes, and behaviors and expresses feelings, the flavor of which is captured in the helper’s response. The response, capturing as it does both the client’s enthusiasm and her lingering fears, is quite useful because the client makes an important distinction between reasonable caution and expecting to worst to happen. She moves on to her need to make things happen, to become more of an agent in her life.

In another example, the client, who is hearing impaired, has been discussing ways of becoming, in her words, “a full-fledged member of my extended family.” The discussion between client and helper takes place through a combination of lip reading and signing.

**CLIENT (enthusiastically):** Let me tell you what I’m thinking of doing. . . . First of all, I’m going to stop fading into the background in family and friends’ conversation groups. I’ll be the best listener there. And I’ll get my thoughts across even if I have to use props. That’s how I really am . . . inside, you know, in my mind.

**HELPER:** Sounds exciting. You’re thinking of getting right into the middle of things . . . where you think you belong. You might even try a bit of drama.

**CLIENT:** And I think that, well, socially, I’m pretty smart. So I’m not talking about being melodramatic or anything. I can do all this with finesse, not just barge in.

**HELPER:** You’ll do it in a natural way. . . . Draw me a couple of pictures of what this would look like.

The client comes up with a proposal for a course of action that will help her take her “rightful place” in conversations with family and friends, thus setting her agenda. The helper’s response recognizes her enthusiasm and sense of determination. They go on to have a dialogue about practical tactics.

When clients announce key decisions or express their resolve to do something, it is important to recognize the core of what they are saying. In the following example, a client being treated for social phobia has benefited greatly from cognitive-behavioral therapy. For instance, in uncomfortable social situations he has learned to block self-defeating thoughts and to keep his attention focused externally—on the social situation itself and on the agenda of the people involved—instead of turning in on himself.

**CLIENT (emphatically):** I’m not going to turn back. I’ve had to fight to get where I am now. But I can see how easy it could be to slide back into my old habits. I bet a lot of people do. I see it all around me. People make resolutions and then they don’t follow through.

**HELPER:** Even though it’s possible for you to give up your hard-earned gains, you’re not going to do it. You’re just not.

**CLIENT:** But what can I do to make sure that I won't? I'm convinced I won't, but . . .

**HELPER:** You need some ratchets. They're the things that keep roller-coaster cars from sliding back. You hear them going click, click, click on the way up.

**CLIENT:** Ah, right! But I need psychological ones. . . .

**HELPER:** And social ones. . . .What's kept you from sliding back so far?

This client is in the implementing-the-action-program stage. In a positive psychology mode, the counselor focuses on his successes. They go on to discuss the kind of "ratchets" he needs to keep him from backsliding.

### **Adopt Useful Tactics for Responding with Empathy**

Here are some hints regarding behaviors that will help you deliver empathy more naturally and with improved quality.

**Give yourself time to think** Beginners sometimes jump in too quickly with an empathic response when the client pauses. "Too quickly" means that they do not give themselves enough time to reflect on what the client has just said in order to identify the core message being communicated. Watch video clips of competent helpers. They often pause and allow themselves to assimilate what the client is saying.

**Use short responses** As I have said before, I find that the helping process goes best when I engage the client in a dialogue rather than give speeches or allow the client to ramble. In a dialogue, the helper's responses can be relatively frequent, but lean and trim. In trying to be accurate, the novice helper is often long-winded, especially if he or she lets the client go on and on before responding. Again, the question "What is the core of what this person is saying to me?" can help you make your responses short, concrete, and accurate.

**Gear your response to the client, but remain yourself** If a client speaks animatedly, telling you how he finally got his partner to listen to his point of view about a new venture, and you reply accurately but in a flat, dull voice, your response is not fully empathic. This does not mean that you should mimic your clients, go overboard, or not be yourself. It means that part of being with the client is sharing in a reasonable way in his or her emotional tone. Consider this example:

**12-YEAR-OLD CLIENT:** My teacher started picking on me from the first day of class. I don't fool around more than anyone else in class, but she gets me anytime I do. I think she's picking on me because she doesn't like me. She doesn't yell at Bill Smith, and he acts funnier than I do.

**COUNSELOR A:** This is a bit perplexing. You wonder why she singles you out for so much discipline.

Counselor A's language is stilted, not in tune with the way a 12-year-old speaks. Here's a different approach.

**COUNSELOR B:** You're mad because the way she picks on you seems unfair.

On the other hand, helpers should not adopt a language that is not their own just to be on the client's wavelength. An older counselor using "hip" language or slang with a young client can backfire; it can sound ludicrous.

### Respond Selectively to Core Client Messages

It is impossible to respond with empathy to everything a client says. Therefore, as you listen to clients, make every attempt to identify and respond to what you believe are core messages—that is, the heart of what the client is saying and expressing, especially if the client speaks at length. Sometimes this selectivity means paying particular attention to one or two messages even though the client communicates many. For instance, a young woman, in discussing her doubts about marrying her companion, says at one time or another during a session that she is tired of his sloppy habits, is not really interested in his friends, wonders about his lack of intellectual curiosity, is dismayed at his relatively low level of career aspirations, and resents the fact that he faults her for being highly ambitious.

**COUNSELOR:** The picture you paint doesn't look that promising, but the mismatch in career expectations is especially troubling.

**CLIENT:** You know, I'm beginning to think that Jim and I would be pretty good friends, even because we're so different. But partners? Maybe that's pushing it.

In this example, the counselor's empathic response helps the client herself to identify what is a core issue. The counselor follows her lead. In the spirit of inclusive empathy, the counselor believes that she can take the lead in exploring her relationship. After all, it is *her* relationship. His summary empathic response at the end allows her to question the direction in which she and her friend are headed. Of course, because clients are not always so obliging, helpers must continually ask themselves as they listen, "What is key? What is most important here?" and then find ways of checking it out with the client. This helps clients sort out things that are not clear in their own minds.

Responding to what is key sometimes means focusing on experiences *or* actions *or* feelings rather than all three. Consider the following example of a client who is experiencing stress because of his wife's poor health and concerns at work.

**CLIENT:** This week I tried to get my wife to see the doctor, but she refused, even though she fainted a couple of times. The kids had no school, so they were underfoot almost constantly. I haven't been able to finish a report my boss expects from me next Monday.

**HELPER:** It's been a lousy week all the way around.

**CLIENT:** As bad as they come. When things are lousy both at home and at work, there's no place for me to relax. I just want to get the hell out of the house and find some place forget it all. . . . Almost run away. . . . But I can't. . . . I mean I won't.

Here the counselor chooses to emphasize the feelings of the client because she believes that his feelings of frustration and irritation are uppermost in



his consciousness right now. This helps him move deeper into the problem situation—and then find a bit of resolve at the bottom of the pit.

At another time or with another client, the emphasis might be quite different. In the next example, a young woman is talking about her problems with her father.

**CLIENT:** My dad yelled at me all the time last year about how I dress. But just last week I heard him telling someone how nice I looked. He yells at my sister about the same things he ignores when my younger brother does them. Sometimes he's really nice with my mother and other times, too much of the time, he's just awful—demanding, grouchy, sarcastic.

**HELPER:** The inconsistency is really getting to you.

**CLIENT:** Absolutely! It's hard for all of us to know where we stand. I hate coming home when I'm not sure which "dad" will be there. Sometimes I come late to avoid all this. But that makes him even madder.

In this response, the counselor emphasizes the client's experience of her father's inconsistency. It hits the mark and she explores the problem situation further.

### Respond to the Context, Not Just to the Words

A good empathic response is based not just on the client's immediate words and nonverbal behavior. It also takes into account the context of what is said, everything that "surrounds" and permeates a client's statement. This client may be in crisis. That client may be doing a more leisurely "taking stock" of where he is in life. You are listening to clients in the context of their lives. The context modifies everything the client says.

Consider this case. Jeff, a White teenager, is accused of beating a Black youth whose car stalled in a White neighborhood. The beaten youth is still in a coma. When Jeff talks to a court-appointed counselor, the counselor listens to what Jeff says in light of Jeff's upbringing and environment. The context includes his family, the people he interacts with in his neighborhood, the racist attitudes of many people in his blue-collar neighborhood, the sporadic violence there, the fact that his father died when Jeff was in elementary school, a somewhat indulgent mother with a history of alcoholism, and easy access to drugs, the "cultural voices" he has listened to with regards to African Americans, and the cultural voices he has listened to at school and at church. Jeff is what he is in part because of all the cultural influences in his life. The following interchange takes place.

**JEFF:** I don't know why I did it. I just did it, me and these other guys. We'd been drinking a bit and smoking up a bit—but not too much. It was just the whole thing.

**HELPER:** Looking back, it's almost like it's something that happened to you rather than something you did, and yet you know, somewhat bitterly, that you actually did it.

**JEFF:** More than bitter! I feel so ashamed . . . so stupid. I've screwed two lives, that kid who did nothing to deserve what happened and my own. It's not like I got up that morning saying that I was going to bash someone that day.

The counselor's response is in no way an attempt to excuse Jeff's behavior, but it does factor in some of the environmental realities. Later on, he will help Jeff challenge himself to decide whether he is to remain a victim of his environment in terms of the prejudices he has acquired, gang membership, family history, and the like or whether he has the convictions, the will, and the guts to do something about it.

### Learn How to Recover from Inaccurate Understanding

Although helpers should strive to be accurate in the understanding they communicate, all helpers can be inaccurate at times. You may think you understand the client and what he or she has said only to find out, when you share your understanding, that you were off the mark. Therefore responding with empathy is a perception-checking tool. If the helper's response is accurate, the client often tends to confirm its accuracy in two ways. The first is some kind of verbal or nonverbal indication that the helper is right. That is, the client nods or gives some other nonverbal cue or uses some assenting word or phrase such as "that's right" or "exactly." This happens in the following example, in which a client who has been arrested for selling drugs is talking to his probation officer.

**HELPER:** So your neighborhood makes it easy to do things that can get you into trouble.

**CLIENT:** You bet it does! For instance, everyone's selling drugs. You not only end up using them, but you begin to think about pushing them. It's just too easy.

On the other hand, when a response is inaccurate, the client often lets the counselor know in different ways. He or she may stop dead, fumble around, go off on a different tangent, tell the counselor "That's not exactly what I meant," or even try to get the helper back on track. Helpers need to be sensitive to all these cues. In the following example, Ben, a man who lost his wife and daughter in a train crash, has been talking about the changes that have taken place since the accident.

**HELPER:** So you don't want to do a lot of the things you used to do before the accident. For instance, you don't want to socialize much anymore.

**BEN (pausing a long time):** Well, I'm not sure that it's a question of wanting to or not. I mean that it takes much more energy to do a lot of things. It takes so much energy for me just to phone others to get together. It takes so much energy sometimes being with others that I just don't try.

**HELPER:** It's like a movie of a man in slow motion—it's so hard to do almost anything.

**BEN:** Right. I'm in low gear, grinding away. And I don't know how to get out of it.

Ben says that it is not a question of motivation but of energy. The difference is important to him. By picking up on it, the helper gets the interview back on track. Ben wants to regain his old energy but he does not know how. His "lack of energy" is most likely some form of depression. And there are a number of ways to help clients deal with depression. This provides an opening for moving the helping process forward.

If you are intent on understanding your clients, they will not be put off by occasional inaccuracies on your part. If the relationship is solid, clients will read your intent and not just the degree of your accuracy. In a sense, there is no such thing as perfect accuracy or the right kind of accuracy or the right degree of accuracy (Biesanz & Human, 2010; Lewis & Hodges, 2012). Fig 4-1 suggests a way of recovering from a failure to understand the client accurately, but recovering from inaccuracy is something that you and your client do together. It can be a relationship building interaction, part of the give-and-take of therapy.

## Use Empathy Wisely to Achieve a Number of Therapeutic Goals **LO 5.4**

Empathy is not just a value translated into a communication skill. It is also a tool for achieving a number of therapeutic goals. Here are three of them. See if you can think of others.

### Use Empathy throughout the Helping Process

Responding with empathy is a mode of human contact, a relationship builder, a conversational lubricant, and a perception-checking intervention. It is always useful. Driscoll (1984), in his common sense way, referred to empathic responses as “nickel-and-dime interventions that each contribute only a smidgen of therapeutic movement, but without which the course of therapeutic progress would be markedly slower” (p. 90). Because empathic responses provide a continual trickle of understanding, it is a way of providing support for clients throughout the helping process. It is never wrong to let clients know that you are trying to understand them from their frame of reference. Of course, thoughtful listening and processing can lead to empathic responses that are much more than “nickel-and-dime” interventions. Clients who feel they are being understood participate more effectively and more fully in the helping process. Because responding with empathy helps build trust, it paves the way for the helper to use stronger interventions, such as inviting clients to engage in self-challenge.

While responding with empathy is an excellent tool for building the helping relationship, it also acts as a stimulus at every stage and step of the process. When clients are understood, they tend to move forward, however “moving forward” is defined. Responding with empathy helps clients move forward early on if it helps clients explore a problem situation or an undeveloped opportunity more realistically. Later empathy helps clients identify and explore possibilities for a better future, craft change agendas, or explore their degree of commitment to an agenda. Once goals are set, empathy helps clients clarify action strategies and set of an action plan. In the action phase, helpers use empathy to help clients identify obstacles to action, overcome them, and accomplish goals.

In the following example, a young woman visits the student services center at her college to discuss an unwanted pregnancy.

**CLIENT:** And so here I am, 2 months pregnant. I don’t want to be pregnant. I’m not married, and I don’t even love the father. To tell the truth, I don’t even think I like him. Oh, Lord, this is something that happens to other people,

not me! I wake up thinking this whole thing is unreal. Now people are trying to push me toward abortion.

**HELPER:** You're still so amazed that it's almost impossible to accept that it's true. To make things worse, people are telling you what to do.

**CLIENT:** Amazed? I'm stupefied! Mainly, at my own stupidity for getting myself into this. I've never had such an expensive lesson in my life. But I've decided one thing. No one, no one is going to tell me what to do now. I'll make my own decisions.

After the helper's empathic response, self-recrimination over her lack of self-responsibility helps the client make a stand. She says she wants to capitalize on a very expensive mistake. It often happens that empathic responses that hit the mark put pressure on clients to move forward. So responding with empathy, even though it is a communication of understanding, is also part of the social-influence process.

### Use Empathic Responses as a Mild Social-Influence Process

Because helpers cannot respond with empathy to everything their clients say, they are always searching for core messages. They are forced into a selection process that influences the course of the therapeutic dialogue. So even responding with empathy can be part of the social-influence dimension of counseling mentioned in Chapter 3. Helpers believe that the messages they select for attention are core primarily because they are core for the client. But helpers also believe, at some level, that certain messages *should* be important for the client. Positive psychologists, for example, suggest the use of **positive empathy** "a type of empathy response that focuses on a client's hidden message of desire for a better life" (Conoley, Pontrellie, Oromendia, Del Carmen Bellow, & Naagata, 2015). Consider an example of a father who has been continually beating himself up over how he is dealing with his son's poor academic performance.

**CLIENT:** I am a terrible parent. I lose my temper and blow up when my son tells me he had another bad report card.

**HELPER:** Could it be that you're being too hard on yourself? If I read you right, you really value being levelheaded and want to be a good father to your son.

**CLIENT:** I never thought about it that way. I guess I am being too hard on myself the same way I am being too hard on him.

Such an empathic response can help clients focus on their desires and to focus on approach (being a better parent) than avoidance (quit losing my temper) goals. Research is clear that approach goals are more effective (Goetz, Robinson, & Meier, 2008). The helper empathizes with the client, albeit from a different more positive vantage point. The helper's identification of this perspective helped refocus the session and push things forward. The response breaks the client's chain of thinking focused on self-loathing. Of course, helpers need to be careful not to put words in a client's mouth.

### Use Empathic Responses as a Way of Bridging Diversity Gaps

This principle is a corollary of the preceding two. Empathic responses based on effective tuning in and listening constitute one of the most important tools you have in interacting with clients who differ from you in significant ways. Responding with empathy is one way of telling clients that you are a learner, especially if the client differs from you in significant ways. Scott and Borodovsky (1990) referred to empathic listening as “cultural role taking.” They could have said “diversity role taking.” In the following example, a younger white male counselor is talking with an elderly African American woman who has recently lost her husband. She is in the hospital with a broken leg.

**CLIENT:** I hear they try to get you out of these places as quick as possible. But I seem to be lying around here doing nothing. Jimmy [her late husband] wouldn't even recognize me.

**HELPER:** It's pretty depressing to have this happen so soon after losing your husband.

**CLIENT:** Oh, I'm not depressed. I just want to get out of here and get back to doing things at home. Jimmy's gone, but there are plenty of people around there to help me take care of myself.

**HELPER:** Getting back into the swing of things is the best medicine for you.

**CLIENT:** Now you got it right. What I need right now is to know when I can go home and what I need to do for my leg once I get there. I've got to get things in order. That's what I do best.

The helper makes assumptions that might be true for him and some people in his culture, but they miss the mark with the client. Her personal culture has no place for just lying around. She's taking her problems in stride and counting on her social system and a return to everyday household life to keep her going. The helper's second response hits the mark and she outlines some of the things she wants. Box 5-1 summarizes factors that go into effective empathic responding.

### Review the Case of Alex, the Client, and Doug, the Helper **LO 5.5**

Here is an example to bring use of empathy to life. The case is based on a real client, but many aspects of the case have been disguised and simplified. It is not a session-by-session presentation. Rather, it illustrates ways in which one client was helped to ask and answer for himself the four fundamental questions outlined above. The client, Alex, is voluntary, verbal, and, generally, cooperative. Here is the background.

Alex, age 20 years, is a single, Asian American, cisgender heterosexual male who presented at a university counseling center because he indicated being “depressed.” He noted that he had few friends and felt lonely. He desired increased social relationships and also wished he had a romantic relationship. Academically a junior, he was uncertain of his chosen major, Business Management. His grades, although solid (3.5 GPA), have started to slip. What prompted his going to the counseling center was a professor noticing a drop in his grades and “looking sad and withdrawn” in class recently.

Alex was born in the United States and his parents emigrated from Thailand about 5 years before he was born. Alex has a 25-year-old sister. He also has extended family on his father's side located in the San Francisco, California area. His parents settled in the Southeastern part of the United States in a small-to-midsize city (population about 70,000) that consists of little racial or ethnic diversity. Alex lived in the same house his entire childhood, an area that could be considered middle class. Alex's parents own a fairly successful buffet style Chinese restaurant that consumed a large amount of their time. Alex and his sister both worked at the restaurant growing up. She graduated from a local university with an accounting degree. She now lives in a large southern city, is single, and works for a Fortune 100 company. Alex has an "okay" relationship with his sister but does not see her often.

His parents spoke only English in the home believing that would help Alex and his sister adjust easier in the home. Alex has never been to Thailand. Growing up, he was often called Chinese and has encountered racism both in his hometown and at college.

When Alex goes to the university counseling center, he has an intake session with a counselor to evaluate his concerns and determine what services he needs. Alex met with Doug, a White male, age 30 who is a doctoral intern. Doug is married and has one child. He grew up in a city similar to Alex's hometown. It is about the same size and lacks racial and ethnic diversity. Alex likes Doug immediately and asks to have him as his counselor. He likes how Doug listens to him, makes him feel "important" in some way. He also likes that Doug said he would work collaboratively with him. And he appreciated the fact that Doug described the collaborative process (the approach taken in this book), a process that includes Doug's asking for feedback every session about his progress and their relationship. All of this is very new for Alex. He has never talked to anyone like this.

Doug quickly recognizes that Alex lacks self-confidence and that he does not feel "comfortable in his own skin." He assumes that the racism he has encountered growing up and in college and the lack of a strong social support system are central to his problem situation. Doug appreciates Alex's earnestness and his wry sense of humor.

Below is an excerpt from their first session. Alex is describing his concerns—depression, lack of motivation in school, and an unsatisfactory social life.

**DOUG:** Sounds like things have really been difficult for you lately, especially since the semester started.

**ALEX:** Definitely. I feel stuck in a rut. I just feel invisible at school, like I don't matter. And when I am noticed it is because I am different.

**DOUG:** Tell me about feeling invisible.

**ALEX:** I hardly have any friends and no one seems interested in talking to me.

**DOUG:** And you think a lot of this has to do with you being different?

**ALEX:** Absolutely! Almost everyone is White here and most don't seem to want to hang out with an Asian. I just wish I were White. (Heavy sigh)

**DOUG:** That's a rather big statement, Alex. You feel left out and you believe you are excluded simply because you are not White.

**ALEX:** I don't know if it's that big. Life would be so much easier. I would be judged on who I am and not what I look like. Although I think it is

unintentional for a lot of people, I get stereotyped and people here don't think of me as someone they would date or hangout with . . . I just thought when I got to college, well, I thought things would be different.

**DOUG:** Sounds like a very lonely place to be. Especially because you thought college would be different. All you want is for people to see you for who you are. It's more than just disappointing.

**ALEX:** I'm angry. I resent being tagged. The list goes on (voice rising). Sorry . . . I don't normally talk so negative, but I have just kept it bottled up for so long (voice rising again). I'm just sick of it!

**DOUG:** So you have to deal with all of this now, tackling a system that seems to be stacked against you.

**ALEX:** Yes, now. I am just so tired of feeling this way. But how can I take on a system?

**DOUG:** Just one person against a system doesn't seem fair.

**ALEX:** But I don't want to feel helpless either. You know, like a wimp.

At this point Doug wants to help Alex get away from the negativity that's pervading the conversation. So he turns to the issue of friends.

**DOUG:** You say that you are lonely or that you are alone in some sense of the word. But can I assume that you do have some friends?

**ALEX:** Well, yes. There's Jake . . . And maybe Adri. Adri is from Colombia. Jake? I think he's from New Zealand.

**DOUG:** Am I right in assuming that you haven't shared any of this with either of them?

**ALEX:** Of course, you're right. They don't seem to have the problem I have.

**DOUG:** So even though they are international students, they're still White? So you wouldn't expect them to have your kind of problem.

**ALEX:** Well, Adri's brown, but very pretty. And Jake. Well, he's White, but he talks with a heavy accent. Or it sounds heavy to me.

**DOUG:** So in a way they're different from most students. But not the same way you're different. In what ways are they different from you?

**ALEX:** They are different mainly because they are totally accepted, part of the group.

**DOUG:** And right now for you, that's the main difference. Any other differences?

**ALEX:** Hmmm . . . Well, they are certainly more social. I see them a lot with other people. Sometimes I see them with each other. And then I feel good about joining them.

**DOUG:** So they get more involved than you. It sounds like they don't think a lot about being different. They just join the group.



**ALEX:** I think I see where we're headed. Are you saying that because I'm not the kind of guy that pushes himself? . . . Maybe "pushes" is the wrong word. Adri and Jake just join the group. They involve themselves with others. They don't even think of being different or being excluded.

**DOUG:** I don't mean to "head" anywhere. I guess I'm trying to get both of us to see the bigger picture. You know, look at things from different angles. A significant difference is that they are not Asian.

**ALEX:** They both "pass" for White. I don't come close.

Doug remained empathic throughout and allowed Alex to express the strong emotions he was having and that he had kept bottled up. But how can Doug help Alex, one person, take on an unfair system? The entrepreneur in Doug is thinking about a lot of things. How do you stop being just one person? Where do you find partners? How do you crack a system? How can a system crack itself? The questions go on and on, setting the tone for the rest of their encounters. But one thing is uncertain: Alex, helped by Doug, has to start NOW. This is the way Doug starts:

**DOUG:** Alex, if you had the life you thought you were going have here at the college, what would it look like? What would be going on that is not going. Describe it to me. I'll help you do it.

So even in their first meeting, Doug helps Alex move to Stage II of the helping process. Describing a better future is a way of letting a little fresh air into the room.

## Explore the Shadow Side of Responding LO 5.6

Some helpers are poor communicators without even realizing it. Many responses that novice or inept helpers make are really poor substitutes for accurate empathic responses. Consider the following example, which includes a range of such responses. Rami is a middle-aged man who has been caught up in an economic collapse. His immediate problem is that his house is being foreclosed. His wife, who until recently did not work outside the home, works as cashier in a supermarket. He has one son in college and another who is about to graduate from high school. His extremely constrained financial condition means that the older son will have to transfer to a state school or even drop out of college. His younger son has no chance of going to the college of his choice. This is his second visit to a counselor in a mental health clinic. In the first session, he said he wanted to "talk through" some issues relating to the "financial transition" he was going through. He was in very difficult financial straits, but appeared to be managing fairly well under the circumstances. In this session, after talking about a number of transition issues, he begins speaking in a rather strained voice and avoids eye contact with the counselor.

Something else is bothering me a bit . . . More than a bit. It's driving me crazy. The reason I'm in such a desperate position is that a partner of mine, seeing the crash coming, robbed me blind. And I mean blind. I didn't see it coming. He manipulated

the finances of our partnership and without going into the details I found myself high and dry. (He pauses) I trusted him. I thought we were more than partners. I thought we were friends. To make things worse, everything he did to defraud me was either impossible to prove or legal. He's ruined me. Worse. He's ruined my family. But I think I've found a way of getting back at him. It won't get my money back. But the honor of my family will be restored. Right now that's all I can think of. I wasn't born or raised here. Back home I'd probably be bound to hunt him down and kill him. That I wouldn't do. But I've hunted him down financially and found ways of doing him in. And I wouldn't be doing anything illegal. No one will know who did it.

Rami pauses and looks at a piece of art on the wall. What would you do or say? The following are some possibilities that are better avoided.

**No response** It can be a mistake to say nothing, though cultures differ widely in how they deal with silence (Sue & Sue, 1990). In North American culture, generally speaking, if the client says something significant, respond to it, however briefly. Otherwise, the client may think that what he or she has just said does not merit a response. Do not leave Rami sitting there stewing in his own juices.

**Distraction questions** Some helpers, like many people in everyday life, cannot stop themselves from asking questions. Instead of responding with empathy, a counselor might ask something like, "Are you sure there is no way to get your money back?" "Did you confront him?" Responses like this ignore Rami's key messages and the feelings he has expressed and focuses rather on the helper's off-target agenda to get more information.

**Clichés** A counselor might say, "Given the greed that has crept into our culture, I'm not at all surprised that things like this happen." Or "The workplace these days is so competitive. It's not uncommon for things like this to come up." This is cliché talk. It turns the helper into an insensitive instructor and must sound dismissive to the client. Clichés are hollow. The helper is saying, in effect, "You don't really have a problem at all because a lot of this stuff goes on." Clichés are a very poor substitute for understanding.

**Interpretations** For some helpers, interpretive responses based on their theories of helping seem more important than expressing understanding. Such a counselor might say something like, "Rami, have you ever thought that revenge will cure nothing and probably make things worse? Revenge is a way of selling yourself short." Here the counselor fails to respond to the client's feelings, sounds moralistic, ignores key messages (such as the meaning of revenge in Rami's culture), and is dismissive.

**Advice** In everyday life, giving unsolicited advice is extremely common. It happens in counseling, too. For instance, a counselor might say to Rami, "Hey, focus on your financial and family concerns. Do what you probably do best. It's a business problem. How many different ways can you solve it?" Advice giving at this stage is out of order and, to make things worse, the advice given has a

cliché flavor to it. Furthermore, advice giving robs clients of self-responsibility. That said, in some cultures clients expect helpers to give advice. Expecting to get advice may also be part of any given client's personal culture. In these cases, there are ways of giving advice that elicits the client's collaboration. I say something like this: "let's see. If I was in a situation like yours, here are a couple of things I might do."

**Parroting** Responding with empathy does not mean merely repeating what the client has said. Such parroting is a parody of responding with empathy. Reread what Rami said, and then evaluate the following response.

**COUNSELOR:** So, Rami, your so-called friend read the economy right, devised his dirty little plan, and pulled it off before you even began to realize what was happening. As you looked at the whole mess, you realized there was little you could do financially. You and your family were already done in. And in the culture you come from that kind of rotten behavior calls for a strong response. You don't want to get into more trouble than you're already in, but there's one thing you can do. You can get your revenge. That's not going to save you financially, but somehow or either it will put things back in balance, at least some kind of social balance. And there's some satisfaction to that.

Most of this is accurate, but it sounds awful. Mere repetition or restatement or paraphrasing carries no sense of real understanding of, no sense of being with, the client. Real understanding, because it passes through you, should convey some part of you. Parroting doesn't. To avoid parroting, tap into the processing you've been doing as you listened, consider what is key, come at what the client has said from a slightly different angle, use your own words, note the emotion, but don't say too much. Remember the saying: "The person who says too much says nothing."

**Sympathy and agreement** Being interpersonally empathic is not the same as agreeing with the client or being sympathetic. An expression of sympathy has much more in common with pity, compassion, commiseration, and condolence than with empathic understanding (Clark, 2010b). Although in many cultures these are fully human traits, they are not particularly useful in counseling. Sympathy denotes agreement, whereas empathy denotes understanding and acceptance of the person of the client. At its worst, sympathy is a form of collusion with the client. Note the difference between Counselor A's response to Rami and Counselor B's response.

**COUNSELOR A:** Boy, I can see that it's really hard to tell a story like this. As a successful businessman, you're probably saying to yourself, "How did I ever let this happen to me?" I know I'd feel awful. It's even worse for someone who is as self-confident as you usually are.

**Rami (pauses):** I guess so.

Rami does not respond very enthusiastically to collusion-talk. He's struggling. He wants some help. The helping process does not move forward. Counselor B takes a different approach.

**COUNSELOR B (pauses):** I'm trying to think what I would do. I think I'd be torn between getting my family back on track and seeing justice done.

**RAMI:** I am torn. I've got clashing emotions. But the need to get even is so strong right now. I never thought of it as taking something away from my family. Thought of giving up on my family seems awful.

Counselor B's response hits a key issue and helps Rami look at both issues that are tearing him apart. Give a critique of Counselor B's response and then formulate your own.

**Faking it** Clients are sometimes confused, distracted, and in a highly emotional state. All these conditions affect the clarity of what they are saying about themselves. Helpers may fail to pick up what the client is saying because of the client's confusion or because clients are not stating their messages clearly. Or the helpers themselves have become distracted in one way or another. In any case, it is a mistake to feign understanding. Genuine helpers admit that they are lost and then work to get back on track again. A statement like "I think I've lost you. Could we go over that once more?" indicates that you think it important to stay with the client. It is a sign of respect. Admitting that you are lost is infinitely preferable to such clichés as "uh-huh," "um," and "I understand." On the other hand, if you often catch yourself saying that you do not understand, then you had better find out what is standing in the way. In any case, faking it is never a substitute for competence.

If you catch yourself making any of these mistakes, then find a way to recover. Helpers are not immune from mistakes. In her book *Learning from Mistakes in Clinical Practice*, Carolyn Dillon (2003) categorizes common mistakes and demonstrates how helpers can learn from them. She describes the "signals" clients send to helpers indicating a mistake is being or has been made. Effective helpers recognize these signals and act on them.

## Some Final Words

Duncan (2010) sums this chapter up well: "Empathy, therefore, is work. You can't take it for granted; instead you have to sort out what the client finds empathic, what engages the client in the work. But it is really worth the effort" (p. 134). Extensive practice in all facets of empathy can be found in Chapter 5 of *Exercises in Helping Skills*, the manual accompanying this text.

Finally, note that all approaches to problem managing and opportunity finding and developing—including design thinking and action learning—see empathy not only as an important first step but also as a value that should permeate the entire process of consulting and helping.



# Master the Art of Probing and Summarizing

### LEARNING OBJECTIVES

#### **6.1 Develop an Appreciation of the Power of Nudging**

#### **6.2 Become Competent in Various Types of Effective Probing**

- Use both Verbal and Nonverbal Prompts
- Learn to Use Different Forms of Probing
- Use Questions Sparingly and Effectively
- Follow the Guidelines for Using Probes
- Follow Probes with Empathic Responses

#### **6.3 Provide Focus and Direction by Using Summaries**

- Use Summaries When They Add Value
- Get Clients to Provide Summaries
- Review the Use of Summaries and Probes in the Case of Marcus and Andrea

#### **6.4 Come to Grips with the Shadow Side of Communication Skills**

- Keep in Mind That Communication Skills Are Necessary but Not Sufficient
- Distinguish between the Helping Relationship and Helping Technologies
- Find Ways of Developing Proficiency in Communication Skills

## Develop an Appreciation of the Power of Nudging LO 6.1

In Chapter 2 it was noted that all attempts to help others involve, to one degree or another, influencing them. Helpers influence their clients. The trick is to influence them to do such things as discussing difficult problems; developing new life-enhancing perspectives on themselves, others, and the world; working on the right issues; exploring possibilities for a better future; choosing and committing themselves to problem-managing goals; exploring ways of achieving these goals; and engaging in the kind of effective and efficient action needed to accomplish all of this—to influence them, certainly, but without robbing them of their freedom. Thaler and Sunstein (2008), in a fascinating and useful book entitled *Nudge*, call this kind of influence “libertarian paternalism.” The influence part is, in some sense, paternalistic and the freedom part is libertarian. Paternalism does not necessarily connote coercion, whether physical or psychological. And libertarian in the sense in which they use the term certainly does not mean, “Do whatever you want.”

In the book they talk about “**choice architects**,” that is, someone who “has the responsibility for organizing the context in which people make decisions” (p. 3). Because decision-making is one of the key ingredients of successful therapy, it is important to explore the role helpers play in organizing the context in which clients make decisions. Because helpers cannot avoid influencing their clients, they are choice architects. Treatment models, including the Skilled Helper framework itself together with the methods and communications skills that make it work, provide different kinds of **choice architecture**. In the hands of savvy and principled helpers the model, methods, and skills of any treatment approach can be used as “**nudges**.” Thaler and Sunstein describe a nudge as “any aspect of the choice architecture that alters behavior in a predictable way without forbidding any options” (p. 6). Of course, the predictability referred to is the predictability of the social rather than the physical sciences. For instance, we have already seen that an empathic response to a client can constitute a nudge in two ways. First of all, because helpers cannot reply empathically to everything a client says, their selective responding is a form of influence. Second, empathic responses tend to influence clients to explore the issue being discussed more broadly or deeply. But, while empathic responses might well (but not necessarily) influence clients, they do not pin clients down. Nudges have power, but they are “gentle.” In the hands of a skillful helper nudges lead to collaboration rather than standing in the way of it. Skillful nudging does not overwhelm clients. It keeps clients at the center of the decision-making process. As we shall see, the next two communication skills, **probing** and **summarizing**, often take the form of nudges. Their “gentle power,” rightly used, can be of great benefit to clients.

Nudging has proved to be so useful that the government of the United Kingdom has set up a “nudge unit” (Halpern, 2016). “Seemingly small and subtle solutions have led to huge improvements across tax, healthcare, pensions, employment, crime reduction, energy conservation, and economic growth.” Behavioral nudges are everywhere in many societies from calorie counts on packaged foods and menus to “annoying” seat-belt notification systems. Cohen,



Lynch, and Robertson (2016; see also Robertson, 2017) have edited a book in which the work of 45 experts in behavior science study the effectiveness and efficiency of nudging in healthcare.

## Become Competent in Various Types of Effective Probing **LO 6.2**

In most of the examples used in the discussion of sharing empathic responses, clients have explored themselves and their behavior relatively easily. Obviously, this is not always the case. Although it is essential that helpers respond with empathy when their clients do reveal themselves, it is also necessary at times to nudge, encourage, or prompt clients to explore their concerns when they fail to do so spontaneously. Therefore the ability to use prompts and probes effectively is another important communication skill. If sharing empathic responses is the lubricant of dialogue, then probes provide often-needed nudges.

Prompts and probes are verbal, and sometimes nonverbal, tactics for helping clients talk more freely and concretely about any issue at every stage of the helping process. For instance, counselors can use probes to help clients identify and explore opportunities they have been overlooking, to clear up blind spots, to translate dreams into realistic goals, to come up with realistic plans for accomplishing goals, or to work through obstacles that are preventing action. Probes, judiciously used, provide focus and direction for the entire helping process. We start with prompts.

### Use Both Verbal and Nonverbal Prompts

Prompts are brief verbal or nonverbal interventions designed to let clients know that you are with them and to encourage clients to talk further.

**Nonverbal prompts** Counselors' various nonverbal behaviors can have the force of probes. For example, a client who has been talking about how difficult it is to make a peace overture to a neighbor with whom she is at odds says, "I just can't do it!" The helper says nothing but, rather, simply cocks his head, leans back with a quizzical look, and waits. The client pauses and then says, "Well, you know what I mean. It would be very hard for me to take the first step. It would be like giving in. You know, weakness." They go on to explore how such an overture, properly done, could be a sign of strength rather than weakness. Such things as bodily movements, gestures, nods, eye movement, and the like can be used as nonverbal prompts or nudges. But they must be natural. They must be you.

**Vocal and verbal prompts** You can use such responses as "um," "uh-huh," "sure," "yes," "I see," "ah," "okay," and "oh" as prompts, provided you use them intentionally and they are not simply a sign that your attention is flagging, that you do not know what else to do, or that you are on automatic pilot. In the following example, a 35-year-old successful engineer has sought the help of a therapist for his intense fear of public speaking that has become problematic since being promoted to a managerial position at his company. Currently, he is anxious about an upcoming meeting he has to lead.

**CLIENT:** I just freeze. I feel my hands get sweaty, my heart rate quickens, and I forget everything we have been working on. I just don't want to make a mistake. If I am not perfect I feel like everyone will say I didn't deserve the promotion [he pauses]. And I know we have talked about it, but I just can't get it through my head that no one is expecting me to be some great speaker. This is just me and my expectations!

**HELPER:** Uh-huh. [The helper says with a nod and a soft smile.]

**CLIENT (laughs):** My emotions are like a fire alarm telling me I am being unrealistic. Of course, my supervisor told me that one of the reasons I got promoted was that we set challenging but realistic goals for our division, that we were an example for the rest of the company. We were methodical. Maybe I should apply that to my public speaking and realize it will take time to be the speaker I want to be or at least need to be.

The helper's small affirmative "Uh-huh" prompts the client to further consider what he has just said. Prompts should never be the main course, but they are useful condiments in the therapeutic dialogue.

## Learn and Use Different Types of Probing

Used judiciously, probes help clients name, take notice of, explore, clarify, or further define an issue at any point in the helping process. They are designed to provide clarity and to move things forward. Probes take different forms.

**Statements** One form of probe is a statement indicating the need for further clarity. For instance, a helper, talking to a client who is having problems with his 25-year-old daughter who is still living at home, says, "It's still not clear to me whether you want to challenge her to leave the nest or not." The client replies, "Well, I want to but I just don't know how to do it without alienating her. I don't want it to sound like I don't care about her and that I'm just trying to get rid of her." Statement probes often take the form of the helper's confessing that he or she is in the dark in some way—"I'm not sure I understand how you intend. . . ." "I guess I'm still confused about. . . ." This kind of request puts the responsibility on clients without accusing them of failing to cough up the truth.

**Requests** Probes can take the form of direct requests for further information or more clarity. A counselor, talking to a woman living with her husband and her mother-in-law, says, "Tell me what you mean when you say that three's a crowd at home." She answers, "I get along fine with my husband, I get along fine with my mother-in-law. But the chemistry among the three of us is very unsettling." This is helpful new information. Obviously, requests should not sound like commands. "Come on, just tell me what you are thinking." Tone of voice and other paralinguistic and nonverbal cues help to soften requests.

**Questions** Direct questions are perhaps the most common type of probe. Whether they should be that common or not is a different issue.

- "How do you react when he flies off the handle?"
- "In situations like that, what keeps you from making a decision?"

- “Now that the indirect approach to getting him to provide for the kids is not working, what might Plan B look like?”

Consider this case. A client has come for help in controlling her anger. With the help of a counselor she comes up with a solid program. In the next session, the client gives signs of backtracking. The counselor says, “You seemed enthusiastic about the program last week. But now, unless I’m mistaken, I hear a bit of hesitancy in your voice. Or am I just hearing things?” The client responds, “Well, after taking a second look at the program, I’m afraid it will make me look like a wimp. My fellow workers could get the wrong idea and begin pushing me around.” The counselor says, “So there’s something about yourself and your style of relating at work that you don’t want to lose.” When the client responds, “That’s right!” The counselor asks, “What might that be?” The client hesitates for a moment and then says, “Spunk!” The counselor replies, “Well, maybe there’s a way of keeping your spunk without giving in to outbursts that get you in trouble.” They go on to discuss the practical differences between assertiveness and aggression.

***Single words or phrases that are, in effect, questions or requests*** Sometimes single words or simple phrases are, in effect, probes. A client talking about a difficult relationship with her sister at one juncture says, “I really hate her.” The helper responds simply and unemotionally, “Hate.” The client responds, “Well, I know that hate is too strong a term. What I mean is that things are getting worse and worse.” This kind of clarity helps. Another client, troubled with irrational fears, says, “I’ve had it. I just can’t go on like this. No matter what, I’m going to move forward.” The counselor replies, “Move forward to . . . ?” The client says, “Well . . . to not indulging myself with my fears. That’s what they are, a form of self-indulgence. From our talks I’ve learned that it’s a bad habit. A very bad habit.” They go on to discuss ways of controlling such thoughts.

Whatever form probes take, they are often, directly or indirectly, questions of some sort. They are an invitation to provide “more”—more information, more thought, or more emotion, depending upon the situation. Therefore a few words about the use of questions are in order.

***Use questions sparingly and effectively*** Helpers, especially novices and inept counselors, tend to ask too many questions. When in doubt about what to say or do, they ask questions that add no value. It is as if gathering information were the goal of the helping interview. On the other hand, questions, judiciously used, can be an important part of your interactions with clients. Here are two guidelines.

***Do not ask too many questions*** When clients are asked too many questions, they feel grilled, and that does little for the helping relationship. Furthermore, many clients instinctively know when questions are just filler that are being used because the helper does not have anything better to say. I have caught myself asking questions, the answers to which I did not even want to know. Let’s assume that the helper is working with Rollie, an inmate in a state facility for young

offenders. He is doing time for burglary and drug use. Because he is difficult to work with and blames everything on his dysfunctional family, the counselor ends up asking a whole series of questions out of frustration:

- “When did you first feel caught in the messiness of your family?”
- “What did you do to try to get away from their influence?”
- “What could you do different?”
- “What kind of friends did you have?”

These questions are no more than a random search for information, the value of which is not clear. Rollie is an expert in evading questions like this. Professionals have grilled him, and when he tires of being questioned, he just clams up. Helping that turns into a question-and-answer session tends to go nowhere.

**Ask open-ended questions** As a general rule, ask open-ended questions—that is, questions that require more than a simple yes or no or similar one-word answer. Not, “Now that you’ve decided to take early retirement, do you have any plans?” but, “Now that you’ve decided to take early retirement, how do you see the future? What plans do you have?” Counselors who ask closed questions find themselves asking more and more questions. One closed question leads to another. Of course, if a specific piece of information is needed, then a closed question may be used. A career counselor might ask, “How many jobs have you had in the past 2 years?” The information is relevant to helping the client draw up a resume and a job-search strategy. Of course, occasionally, a sharp closed question can have the right impact. For instance, a client has been outlining what he was going to do to get back at his “ungrateful” son. The counselor asks, “Is getting back at him what you really want?” Rhetorical questions like this are a form of challenge. If the client responds by saying, “You’re damn right I do!” then you know more about the intensity of his feelings. And you know you are facing a tricky issue. In general, though, open-ended questions in moderation can help clients fill in what is missing at every stage of the helping process.

**Respond constructively to questions clients ask** Waehler and Grandy (2016) have studied this. Their research indicates that too many helpers respond poorly to clients’ questions. Actually, clients’ questions offer opportunities for collaboration.

Unfortunately, therapists often feel that they must choose between the extremes of answering a client’s question fully, thereby maintaining a strong client–therapist relationship (and perhaps exercising their own desire to be seen as competent and knowledgeable) while inhibiting the client’s ability to achieve further insight, or, conversely, refusing to answer the client’s questions, thereby having the client ponder the answer in isolation and putting the client–therapist relationship in jeopardy.

Edelstein and Waehler (2011) establish guidelines for constructively responding to clients’ questions. First, be open to questions and show respect is listening to such questions. Take the questions seriously. Second, explore what is going on in the client’s mind. Encourage clients to be curious. Third, answer the questions as fully as it merits. Keep the client engaged. Fourth, explore the dynamics of the

question with the client. Discuss the meaning of the question in a positive way. Note that these guidelines can also be applied to your questions. For instance, if you ask a question and the client asks, “Why do you want to know that?” be ready to respond constructively.

### Follow the Guidelines for Using Probes

Here, then, are some suggestions that can guide you in the use of all probes, whatever form they may take.

**Use your ongoing feedback system as a way of probing** Whether you use measures such as Duncan’s or some other way of systematically getting feedback from the client on both progress toward and the achievement of outcomes and quality of therapy sessions, the feedback system is an excellent opportunity for probing. Consider these two brief examples. In the first example, Leena is a single mother who lost her fairly well-paying job during the economic disaster. She was a “hip” drinker when times were good but turned into a problem drinker when things turned sour. She spent what she earned on her lifestyle so there was no financial cushion when things went south. She felt sorry for herself and spent a lot of time railing against all the usual suspects everyone was blaming for the financial crash. In the first session she understandably rated herself rather low on the how-are-you-doing-individually scale. Her rating went up significantly in the second session because she thought that counseling was the answer. But here in the third session she rates herself lower than she did in the first session.

**HELPER:** I see the ‘Individual’ score has taken a hit, Leena. What’s the message? . . . I think I might be reading it in your face and posture.

**LEENA:** I felt so good after the last session. I was fired up. My hopes were high; they were flying. I was going to take my life back. But two days later I received a couple of default notices. My boss told us we would all have to take a cut in pay. And my boyfriend described me as “scary.” My world collapsed. I collapsed. I just don’t know how I’m going to recover.

**HELPER:** So, for a while you soared, then the crash.

**LEENA (emphatically):** I was shot down!

**HELPER:** Shot down?

**LEENA:** Yes, I was attacked on all sides. Bank, work, boyfriend. Even the kids ganged up on me.

**HELPER:** You said your hopes soared. Tell me more about that.

**LEENA:** Well, I thought it was going to be easy to pull everything together. I just felt so good. Now I’m thinking that I can’t pull this off at all. It’s just too much. It’s going to take so much work. Budgets. Working out repayment schedules. I have to create a whole new lifestyle. **HELPER:** The misery is very real. But let’s put it aside for a moment. What good might come from all of this? What could you mine from it?

**LETTA (pauses):** Nothing! (The helper remains silent.) . . . (in a more subdued voice) I suppose I could become more realistic. . . . Come back to earth.

**HELPER:** OK. Let's see what this "realism" might look like.

They go on to draw a picture of what a more "realistic" lifestyle might look like. Leena gradually relaxes as they discuss possibilities.

The second example deals with the therapeutic alliance measure at the end of the session. Leena rates the "Overall" category higher than the other two sessions.

**HELPER:** Well, Leena, what made this session work for you?

**LEENA:** One very bittersweet word. Realism.

**HELPER:** OK. How did that work?

**LEENA:** It triggered something in me. I hate self-centered people and all of a sudden I saw myself as self-centered (she stops).

**HELPER:** I'm not sure I understand the interplay between "realism" and "self-centered" and your score for the session.

**LEENA:** One lesson from the financial crash is that we were all—well, many of us—were living beyond our means. Maybe our whole society, government and all. Like a national self-centeredness. I feel that I'm a fairly intelligent person. But all that was stupid. The dose of realism during this session was very good for me, especially because we went about it in a constructive way.

This session opened the door to progress, to life-enhancing outcomes. During the dialogue realism was defined in terms of concrete possibilities. This edged Leena away from the brink of "impossible" and she recaptured some of her enthusiasm, but perhaps a more realistic brand.

### ***Use probes to help clients engage as fully as possible in the therapeutic dialogue***

As noted earlier, many clients do not have all the communication skills needed to engage in the problem-managing and opportunity-developing dialogue. Probes are the principal tools needed to help all clients engage in the give-and-take of the helping dialogue. Consider Cornell, a counselor in a community mental health center, and a client, Allen, who is seeking treatment because his wife has said he must go to counseling because of an act of infidelity. "Go," she said, "or the marriage is over." Both Allen and his wife described their marriage as "happy" and "good" before Allen had the one-night stand. Allen was a regional manager of a mid-size company. The incident happened during a business trip. He was traveling with a woman who was a sales representative at one of the regional offices he managed. Allen said she had flirted with him for months. He went to dinner with her and they ended up going back to his motel room. In his first session, he explains that he was not really attracted to his colleague and does not know why he slept with her.

**ALLEN:** I didn't have any feelings for her. Still don't. I just went along with it. I don't think I would do it again. But then why not? It happened so easily.

**CORNELL:** You seem concerned that you didn't feel anything, that your feelings should have been a signal.

**ALLEN:** Yeah, I guess so. I just don't ever seem to feel anything.

**CORNELL:** Do you feel guilty about what happened?

**ALLEN:** Not really. I know I should but I don't feel that either.

They continue to discuss Allen's lack of feeling and not experiencing emotional connection for the next couple of sessions. Allen has long wondered what was wrong. He did not get sad at funerals or as he said, "even when the family cat died." He cares about his wife and wants to stay with her, but does not experience a deep emotional connection with her. He has lots of friends and good interpersonal skills. Cornell also likes him. However, he does not have a "best" or "good" friend with whom he feels connected. Cornell suspects that Allen struggles with "alexithymia," a term used to describe someone who has difficulty expressing or identifying emotions within one's self or others. They discuss this possibility; Allen agrees that it makes sense. He said he grew up in a "broken family" where he got little attention except when he was in trouble. Even then he said his parents seemed preoccupied with their own problems. He described his upbringing as "sterile." Here is an excerpt from their third session. They have agreed to work on identifying and expressing emotions.

**ALLEN:** Yeah, I worry that I will be unfaithful again but, at the same time, I have no desire to do so.

**CORNELL:** Tell me more about the "worry" part.

**ALLEN:** I did . . . I mean I don't want to mess up my family. I don't want to cause my daughter any pain.

**CORNELL:** You mean, like the pain you experienced when you were growing up?

**ALLEN:** I do (looking more intently).

**CORNELL:** What that was like for you?

**ALLEN:** Everything was so unpredictable I didn't know what was going to happen next. I don't want that for her. Always on edge.

Note how Cornell uses nudges. First, he notes that Allen used the term "worry." There was no "aha, you do feel!" but a subtle identification of a feeling. Second, he notes that he feels empathy for his daughter and connects it to his own experience as a child in his "broken family." Cornell asks what that was like for Allen. Notice he does not ask him how he feels because, in one way or another, Allen has already told him. "How do you feel?" is so often an insipid question. The nudges are meant to help Allen realize that he does have emotions and, at the right time, can express them. There is certainly more work to be done. Therapy is not easy for Allen. But Cornell's strategic nudges and probes gently help Allen get in touch with the world of emotion.

***Use probes to help clients achieve concreteness and clarity*** Probes can help clients turn what is abstract and vague into something concrete and



clear—something you can get your hands on and work with. In the next example, a man is talking about an intimate relationship that has turned sour.

**CLIENT:** She treats me badly, and I don't like it!

**HELPER:** Tell me what she actually does.

**CLIENT:** She talks about me behind my back. I know she does. Others tell me what she says. She also cancels dates when something more interesting comes up.

**HELPER:** That's pretty demeaning. . . . How have you been reacting to all this?

**CLIENT:** Well, I think she knows that I have an idea of what's going on. But we haven't talked about it much. Well, not at all.

In this example, the helper's probe leads to a clearer statement of the client's experience and behavior. By sharing empathic responses and using probes, the helper discovers that the client puts up with a great deal because he is afraid of losing her. He goes on to help the client deal with the psychological "economics" of such a one-sided relationship.

In the next example, a man who is dissatisfied with living a somewhat impoverished social life is telling his story. A simple probe leads to a significant revelation.

**CLIENT:** I daydream about things that make me feel good.

**HELPER:** What kinds of things?

**CLIENT:** Well, I daydream about that in the near future I will have a different life. I am in great shape, have a better job, and I always have the answers. People look up to me and realize that actually my quietness is a strength that they are drawn to. I have good friends.

**HELPER:** You daydream about having a different life. In that life, what you usually see as a weakness, your quietness, is really a strength. And that you see this happening soon. Do I have that right?

**CLIENT:** Yes. It is a mixture of mainly unrealistic thoughts sprinkled in with a few realistic ones. I guess daydreaming about things being different, being better, makes it easy for me to deal with how unhappy I am with my social life. Saying it out loud makes me realize that daydreaming helps keep me from doing anything about it now.

The helper's probe leads to a clearer statement of what is going on in the client's head. Helping the client explore his fantasy life could be a first step toward finding out what he really wants. What are the possibilities? His daydreaming, paradoxically, keeps him rooted in a life he does not want.

The next client has become the breadwinner since her husband suffered a stroke. Someone takes care of her husband during the day.

**CLIENT:** Since my husband had his stroke, coming home at night is rather difficult for me. I just. . . . Well, I don't know.

**HELPER:** It really gets you down. . . . What's it like?

**CLIENT:** When I see him sitting immobile in the chair, I'm filled with pity for him and the next thing I know it's pity for myself and it's mixed with anger or even rage, but I don't know what or whom to be angry at. I don't know how to focus my anger. Good God, he's only 42 and I'm only 40!

In this case, the helper's probe leads to a fuller description of the intensity of the client's feelings and emotions, her sense of desperation. In each of these cases, the client's story gets more specific. Of course, the goal is not to get more and more detail. Rather, it is to get the kind of detail that makes the problem or unused opportunity clear enough to see what can be done about it.

**Use probes to explore and clarify clients' points of view, intentions, proposals, and decisions** Clients often fail to clarify their points of view, intentions, proposals, and decisions. For instance, a client might announce some decision she has made. But the decision itself is unclear, and the reasons behind it and the implications for the client and others are not spelled out. In the following case, the client has had a bad automobile accident while driving under the influence. Luckily, he was the only one hurt. He is recovering physically, but his psychological recovery has been slow. The accident opened up a Pandora's box of unresolved psychological problems—for instance, a lack of self-responsibility. A counselor has been helping him work through some of these issues. The following exchange takes place during an early session.

**CLIENT:** I don't think that the laws around driving under the influence should be as tough as they are. I'm scared to death of what might happen to me if I ever had an accident again.

**COUNSELOR:** So you feel you're in jeopardy. . . . I'm not sure why you think that the laws are too tough?

**CLIENT:** Well, they bully us. One little mistake and bingo! Your freedom goes out the window. Laws should make people free.

**COUNSELOR:** Well, let's explore a little. Hmm, let's say all laws on driving under the influence were dropped. Then, starting from zero, you were asked to start adding ones that make sense. Where would you start?

The counselor knows that the client is running away from taking responsibility for his actions. Using probes to get him to spell out the implications of his point of view on DUI laws is the beginning of an attempt to help the client face up to himself.

In a later session, the client talks about the legal ramifications of the accident. He has to go to court.

**CLIENT:** I've been thinking about this. I'm going to get me a really good lawyer and fight this thing. I talked with a friend, and he thinks he knows someone who can get me off. I need a break. It might cost me a bundle. After all, I messed up someone's property a bit, but I didn't hurt anyone.

**COUNSELOR:** What's the best thing that could happen in court?

**CLIENT:** I'd get off scot-free. Well, maybe a slap on the wrist of some kind. A warning.

**COUNSELOR:** And what's the worst thing that could happen?

**CLIENT (a long pause):** I haven't given that a lot of thought. I don't really know much about the laws or the courts or how tough they might be. That sort of stuff. But with the right lawyer. . . .

**COUNSELOR:** Hmm. I'm trying to put myself in your shoes. . . . I think I'd try to find out how cases like mine tend to go in court. . . . I'd like to know that before spending a lot of money on a defense lawyer. . . . What do you think?

The counselor is using probes to help the client explore the possible unintended consequences of a decision he is making.

The state has very tough DUI laws. In the end, because the client's blood-alcohol level was so high, his license is suspended for six months, he is fined heavily, and he has to spend a month in jail. All of this is very sobering. The counselor visits him in jail and they talk about the future.

**CLIENT:** I feel like I've been hit by a train.

**COUNSELOR:** You had no idea that it would be this bad.

**CLIENT:** Right. No idea. . . . I know you tried to warn me in your own way, but I wasn't ready to listen. . . . Now I have to begin to put my life back together. Though I don't feel like it.

**COUNSELOR:** But now that you've had the wake-up call, a horrible wake-up call, it might make sense to start piecing the future together. What do you think?

**CLIENT:** I've been thinking. One thing I want to do is to make some sort of apology to my family. They're hurting as bad as I am. I feel so awkward. I know how to act in cocky mode. Humble mode I'm not used to. Do I write a long letter? Do I wait and just apologize through my actions? Do I take each one of them aside? I don't know, but I've just got to do it.

**COUNSELOR:** Somehow you have to make things right with them. Just how, well that's another matter. Maybe we could start by finding out what you want to accomplish through an apology, however it's done.

Here we find a much more sober and cooperative client. He proposes, roughly, a course of action. The counselor supports his need to move beyond past stupidities and present misery. It's about the future, not the past. The counselor's last statement is a probe aimed at giving substance and order to the client's proposal. It asks the client, what do you want to accomplish?

**Use probes to help clients fill in missing pieces of the picture** Probes further the therapeutic dialogue by helping clients identify missing pieces of the puzzle—thoughts, experiences, behaviors, and feelings that would help both clients and helpers get a better fix on the problem situation, unused opportunity, possibilities for a better future, or drawing up a plan of action. In the following example, the client is at odds with his wife over his mother-in-law's upcoming visit.

**HELPER:** I realize now that you often get angry when your mother-in-law stays for more than a day. But I'm still not sure what she does that makes you angry.

**CLIENT:** First of all, she throws our household schedule out and puts in her own. Then she provides a steady stream of advice on how to raise the kids. My wife sees this as an “inconvenience.” For me it’s a total family disruption. When she leaves, there’s a lot of emotional cleaning up to be done.

Just what the client’s mother-in-law does to get him going has been missing. Once the behavior has been spelled out in some detail, it is easier to help him come up with some remedies. Still missing, however, is what he does in the face of his mother-in-law’s behavior. The helper continues:

**HELPER:** So when she takes over everything gets turned upside down. . . . How do you react in the face of all this turmoil?

**CLIENT:** Well . . . well . . . I guess I go silent. Or I just get out of there, go somewhere, and fume. After she’s gone, I take it out on my wife, who still doesn’t see why I’m making such a fuss.

So now it’s clear that the client does little to change things. It is also obvious that he has not considered how he might influence the situation.

In the next example, a collegiate tennis player, Maria, a young woman from Mexico where her family lives, was encouraged to meet with the athletic department’s psychologist. Her coach is concerned that Maria does not seem to be herself. She “tightens up” during matches. Maria reluctantly goes, but she is also aware that she has not been feeling like her normal “confident” self.

**HELPER:** This lack of self-confidence. Is this something new? Or does it come and go? Tell me a bit about it.

**MARIA:** Pretty much ever since the spring season started. It is kind of like I am a different player. I just can’t seem to get thing clicking like normal. And so when I get in matches, I start getting tight and quit trusting my game.

**HELPER:** So this is relatively new.

**MARIA:** Yes. I have begun to worry a lot. I can’t seem to stay focused.

**HELPER:** So what do you worry about?

**MARIA:** I’m usually focused. I think of strategy and how make the next shot. I was just playing.

**HELPER:** But it seems that something has disrupted “just playing.” Playing well, making the shots was your usual focus. Now. . . .

**MARIA:** Now my mind wanders to things like “what will happen if I lose?” Even when I know I’m better than my opponent. I get distracted and the next thing you know, I lose the point.

**HELPER:** So this isn’t the usual you. Any hunches of what has changed for you?

**MARIA:** I am not sure. I got back from seeing my family in Mexico over the semester break and everything seems different. It was so hard to leave them this time. I’m not a political person at all, but they were worried. It’s contagious. Right now it’s scary as a Mexican in the United States. This is new for me. Traveling was always exciting, but now I was worried they would not let me

through customs. It made me feel like I was doing something wrong and even worse like I didn't deserve to be here. To top it off, money is tight at home, my mom's health is not good, and it was clear my parents were stressed. It just made me want to stay home. But talking about college and my tennis success makes my parents so happy. They're so proud. Here I am supposed to have this great experience and, yet, it does not feel like that right now.

**HELPER:** That's a lot for you to be carrying around with you. So being here is both a joy and a problem.

**MARIA:** It's always been a joy! I love it here. My parents love me being here. Otherwise I'd go back and be with them.

**HELPER:** What makes you want to stay here?

**MARIA:** Two things. My parents want me to be here. They love it. . . . The second is—this might sound odd—I belong here. I have a sports scholarship. The university is doing its job. I'm doing mine. I'm getting an excellent education. It's been working very well, until now. Now politics around the world, Mexico included, seems to be crazy. It's something I don't know how to solve.

**HELPER:** Maybe "solve" is not the right word.

**MARIA:** What do you mean?

**HELPER:** Some problems are so big, so complicated, and so deeply rooted that no one can "solve" them. You are facing a lot of political turmoil. Millions of people are. You cannot "solve," but you can "manage" problems like that.

**MARIA:** How do I manage? What does that mean? I haven't been thinking about the political climate. I just keep thinking that I'm not doing well. And it's making me make more mistakes.

Maria's counselor goes on to help her cut a huge social problem to size. This is the first step in managing. The psychologist continued to use multiple probes derived from the problem management process to help her understand how she had become the target of irrational prejudice. Managing meant continuing to be the best possible student and the best possible tennis player even when under stress. The counselor helped explore ways of dealing with prejudice.

***Use probes to help clients get a balanced view of problem situations and opportunities*** In their eagerness to discuss an issue or make a point, clients often describe one side of a picture or one viewpoint. Probes can be used to help them fill out the picture. In the following example, the client, a manager who has been saddled with a bright, highly ambitious and aggressive young woman who plays politics to further her own interests, has been agonizing over her plight.

**COUNSELOR:** I've been wondering whether you see any upside to this. Any hidden opportunities.

**CLIENT:** I'm not sure what you mean. It's just a disaster.

**COUNSELOR:** Well, you strike me as a pretty bright person. I'm wondering if there are any lessons for you hidden in all this.

**CLIENT (pausing):** Oh, well, you know I tend to ignore politics around here, but now it's in my face. Where there are people, there are politics, I suppose. I think she's being political to serve her own career. But I don't want to play her game. There must be some other kind of game or something that would let me keep my integrity. The days of avoiding all of this are probably over.

The problem situation has a flip side. It is an opportunity for rethinking and learning. As such, problems are incentives for constructive change. The client can learn something through all this. It is an opportunity to come to grips with the interpersonal dynamics of the workplace and a chance to explore "positive" political skills.

***Use probes to help clients move into more beneficial stages of the helping process*** Probes can be used to help clients engage in dialogue about any part of the helping process—telling their stories more fully, surfacing blind spots, setting goals, formulating action strategies, discussing obstacles to action, and reviewing actions taken. Clients sometimes do not easily move into whatever stage of the helping process might be most useful for them. Probes can help them do so. For example, Leslie is talking with a health psychologist about making significant lifestyle changes after her heart attack. She is anxious to get started but is overwhelmed by how to get started and has outlined multiple changes she wants to make.

**COUNSELOR:** Leslie, you have some good ideas here, and yet it is like you are going in a thousand different directions at once.

**LESLIE (speaking hurriedly):** I know. I just feel like if I don't hurry up and start with the next chapter in my life—the "healthy me" chapter. Having my heart attack was a wake-up call to change my habits.

**COUNSELOR:** Let's slow down and catch our breaths for a second. This wake-up call seems to be more than just about changing your lifestyle.

**LESLIE (beginning to cry and looking down):** I'm . . . I'm just so scared. I thought I was going to die, my whole life flashed before my eyes. Like in a novel or movie. It was so surreal, like it was happening to someone else.

**COUNSELOR:** That does sound scary. Maybe we should start there, you have been through so much.

**LESLIE:** Maybe I should slow down . . . that is good for my heart, right? (looking up and smiling faintly). It has all been a bit much for me and I have just kept it bottle up trying to pretend everything was okay, that I would just fix it. But it is not.

The counselor uses probes to get Leslie to tell her story fully, to share more completely what was going on with her. She had a traumatic experience, a life-changing experience, and needs to talk about it before moving forward to

manage her problem. There is a danger of getting ahead of the client. But, as Leslie demonstrates, sometimes we have to go back and get the client's full story before intelligently moving ahead to action.

The next example is about how to help move the client forward. This client has been talking endlessly about the affair her husband is having. Her husband knows that she knows.

**COUNSELOR:** You've said you're not going to do anything about it because it might hurt your son. But doing nothing is not the only possible option. Let's just name some of them. Who knows? We might find a gem.

**CLIENT:** Hmm. . . . I'm not sure I know.

**COUNSELOR:** Well, you know people in the same predicament. You've read novels, seen movies. What are some of the standard things people do? I'm not saying do them. Let's just review them.

**CLIENT:** Hmm. . . . Well, I knew someone in a situation like this who did an outrageous thing. She knew her teenage daughter was aware of what was going on. So one night at dinner she just said, "Let's all talk about the affair you're having and how to handle it. It's certainly not news to any of us."

**COUNSELOR:** All right, that's one possible way. Let's hear some more.

This primes the pump. The counselor uses a few more probes to put a number of possibilities on the table. The focus on action brings energy to the session.

In the following example, Jill, the helper, and Justin, the client, have been discussing how Justin is letting his impairment—he has lost a leg in a car accident—stand in the way of his picking up his life again. The session has bogged down a bit. The helper takes an entrepreneurial approach.

**JILL:** Let's try a bit of drama. I'm going to be Justin for a while. You're going to be Jill. As my counselor, ask me some questions that you think might make a difference for me. Me, that is, Justin.

**JUSTIN (pausing a long time):** I'm not much of an actor, but here goes nothing. . . . Why are you taking the coward's way out? Why are you on the verge of giving up? (His eyes tear up.)

Jill gets Justin to formulate the probes. It is her way of asking Justin to "move forward" and take responsibility for his part of the session. Justin's "probes" turn out to be challenges, almost accusations, certainly much stronger than anything Jill would try. However painful this is for Justin, it is a breakthrough.

***Use probes to invite clients to challenge themselves*** In the last chapter we saw that even sharing empathic responses can act as a mild form of social-influence or challenge. We also saw that effective responses often act as probes. That is, they can be indirect requests for further information or ways of steering a client toward a more productive stage of the helping process. And, as you have probably noticed in the examples used in this chapter, probes can edge much closer to outright invitations to self-challenge. Many probes are not just requests



for relevant information. They often place some kind of demand on the client to respond, reflect, review, or reevaluate. Probes can serve as a bridge between communicating understanding to clients and helping them challenge themselves. The following client, having committed himself to standing up to some of his mother's possessive ways, now shows signs of weakening in his resolve.

**HELPER:** The other day you talked of “having it out with her”—though that might be too strong a term. But just now you mentioned something about “being reasonable with her.” Tell me how these two differ.

**CLIENT (pausing):** Well, I think you might be witnessing a case of cold feet. . . . She's a very strong woman.

The counselor helps the client revisit his decision to “get tough” in some decent way with his mother and, if this is what he really wants, what he can do to strengthen his resolve. Using probes as mild forms of challenge is perfectly legitimate provided you know what you are doing?

### Follow Probes with Empathic Responses

The trouble with dealing with skills one at a time is that each skill is taken out of context. In the give-and-take of any given helping session, however, the skills must be intermingled in a natural way. In actual sessions, skilled helpers continually tune in, listen actively, and use a mix of probes and empathy to help clients clarify and come to grips with their concerns, deal with blind spots, set goals, make plans, and get things done. There is no formula for the right mix. That depends on the client, client needs, the problem situation, possible opportunities, and the stage of the helping process.

Here is a basic guideline about sharing empathic responses and using probes. After using a probe to which a client responds, respond with empathy to what the client has to say. Check your understanding. Be hesitant to follow one probe with another. The logic of this is straightforward. First, if a probe is effective, it will yield information that needs to be listened to and understood. Second, an empathic response, if accurate, tends to place a demand on the client to explore further. It puts the ball back in the client's court.

In the following example, the client is a young Chinese American woman whose father died in China and whose mother is now dying in the United States. She has been talking about the not uncommon subservience of Chinese women and her fears of slipping into a form of passivity in her American life. She talks about her sister, who gives everything to her husband without looking for anything in return. The first counselor sticks to probes.

**COUNSELOR A:** To what degree is this self-effacing role rooted in your culture?

**CLIENT:** Well, being somewhat self-effacing is certainly in my cultural genes. And yet I look around and see many of my North American counterparts adopt a very different style. A style that frankly appeals to me. But last year, when I took a trip back to China with my mother to meet my half sisters, the moment I landed I wasn't American. I was totally Chinese again.

**COUNSELOR A:** What did you learn there?

**CLIENT:** That I am Chinese!

The client says something significant about herself, but instead of responding with understanding, the helper uses another probe. This elicits only a repetition, with some annoyance, of what she had just said. Now consider a different approach.

**COUNSELOR B:** You learned just how deep your cultural roots go.

**CLIENT:** And if these roots are so deep, what does that mean for me here? I love my Chinese culture. I want to be Chinese and American at the same time. How to do that, well, I haven't figured that out yet. I thought I had, but I haven't.

In this case, an empathic response works much more effectively than another probe. Counselor B helps the client move forward.

In the next example, a single middle-aged woman working in a company that has reinvented itself after a downturn in the economy still has a job, but the pay is much less and she is doing work she does not enjoy. She does not have the computer and Internet-related skills needed for the better jobs. The digital world and social media are mysteries to her. She feels stuck, stressed, and depressed.

**CLIENT:** Well, I suppose that I should be grateful for even having a job. But now I work longer hours for less pay. And I'm doing stuff I don't even like. My life is no longer mine.

**HELPER:** So the extra pressure and stress makes you wonder just how "grateful" you should feel.

**CLIENT:** Precisely. . . . And the future looks pretty bleak.

**HELPER:** What could you change in the short term to make things more bearable?

**CLIENT:** Hmm. . . . Well, I know one way. We all keep complaining to one another at work. And this seems to make things even worse. I can stop playing that game. It's one way of making life a bit less miserable.

**HELPER:** So one way is to stop contributing to your own misery by staying away from the complaining chorus. . . . What might you start doing?

**CLIENT:** Well, there's no use sitting around hoping that what has happened is going to be reversed. I've been really jolted out of my complacency. I assumed with the economy humming again I'd find things easy. The economy may be humming, but jobs, good jobs, are still scarce. But I'm still young enough to acquire some more skills. And I do have some skills that I haven't needed to use before. I'm a good communicator, and I've got a lot of common sense. I work well with people. There are probably some jobs around here that require those skills.

**HELPER:** So, given the wake-up call, you think it might be possible to take unused skills and reposition yourself at work.

**CLIENT:** Repositioning. Hmm, I like that word. It makes a lot of pictures dance through my mind. . . . Yes, I need to reposition myself.

**BOX 6.1****Guidelines in Using Probes**

- Keep in mind the goals of probing. Use probes to:
  - Help clients engage as fully as possible in the therapeutic dialogue.
  - Help nonassertive or reluctant clients tell their stories and engage in other behaviors related to managing their problems and developing opportunities.
  - Help clients identify experiences, behaviors, and feelings that give focus to their stories.
  - Help clients open up new areas for discussion.
  - Help clients explore and clarify stories, feelings, points of view, decisions, and proposals.
  - Help clients be as concrete and specific as possible.
  - Help clients remain focused on relevant and important issues.
  - Help clients move on to a further stage of the helping process.
- Use probes to provide nudges or mild challenges to clients to examine the way they think, behave, and act both within helping sessions and in their daily lives.
- Make sure that probing is done in the spirit of empathy.
- Use a mix of statements, open-ended questions, prompts, and requests, not questions alone.
- Follow up a successful probe with an empathic response rather than another probe.
- Use whatever judicious mixture of empathic responses and probing is needed to help clients clarify problems, identify blind spots, develop new scenarios, search for action strategies, formulate plans, and review outcomes of action.

This combination of empathic responses and probing gets things moving. Instead of focusing on the misery of the present situation, the client names a few possibilities for a better future.

You should be careful not to become either an empathic response “machine,” grinding out one after another, or an “interrogator,” peppering your clients continually with needless probes. All responses to clients, including probes and challenges, are empathic if they are based on a solid understanding of the client’s core messages and points of view. All responses that build on and add to the client’s remarks are implicitly empathic, which cuts down on the need to share a steady stream of empathic responses. Box 6.1 summarizes guidelines for using probes.

**Provide Focus and Direction by Using Summaries** **LO 6.3**

The communication skills of visibly tuning in, listening, responding with empathy, and probing need to be orchestrated in such a way that they help clients focus their attention on issues that make a difference. The ability to summarize

and to help clients summarize the main points of a helping interchange or session is a skill that can be used to provide focus, direction, and challenge.

### **Use Summaries When They Add Value**

Brammer (1973) listed several goals that can be achieved by judicious use of summarizing—“warming up” the client, focusing scattered thoughts and feelings, bringing the discussion of a particular theme to a close, and prompting the client to explore a theme more thoroughly. There are certain times when summaries prove particularly useful: at the beginning of a new session, when the session seems to be going nowhere, and when the client needs a new perspective.

***At the beginning of a new session*** Using summaries at the beginning of a new session, especially when clients seem uncertain about how to begin, prevents clients from merely repeating what has already been said before. It puts clients under pressure to move on. Consider this example: Liz, a social worker, begins a session with a rather overly talkative man by summarizing the main points from the previous session. This serves several purposes. First, it shows the client that she had listened carefully to what he had said in the last session and that she had reflected on it after the session. Second, the summary gives the client a jumping-off point for the new session. It gives him an opportunity to add to or modify what was said. Finally, it places the responsibility for moving forward on the client. The implied sentiment of the summary is: “Now where do you want to go with this?” Summaries put the ball in the client’s court and give them an opportunity to exercise initiative. Of course, if you are getting feedback from clients at the beginning and at the end of each session, the flow from session to session will be much smoother.

***During a session that is going nowhere*** Helpers can use a summary to give focus to a session that seems to be going nowhere. One of the main reasons sessions go nowhere is that helpers allow clients to keep discussing the same things over and over again instead of helping them either go more deeply into their stories, focus on possibilities, and goals, or discuss strategies that will help clients get what they need and want. For instance, Marcia is a coach, consultant, and counselor who is working with the staff of a shelter for the homeless. One of the staff members is showing signs of burnout. In a second meeting with Marcia, she keeps going over the same ground, talking endlessly about stressful incidents that have taken place over the last few months. At one point Marcia provides a summary.

**MARCIA:** Let’s see if I can pull together what you’ve been saying. The work here, by its very nature, is stressful. You’ve mentioned a whole string of “incidents” such as being hit by someone you were trying to help or the heated arguments with some of your coworkers. But I believe you’ve intimated that these are the kinds of things that happen in these places. Shelters are prone to them. They are part of the furniture. They’re not going to stop. But they can be very punishing. At times you wish you weren’t here. But if you’re going to stay and if these kinds of incidents are

not going to stop, maybe some questions might be, “How do I cope with them? How do I do my work and get some ongoing satisfaction from it? What changes can we make around here that might lessen the number of these incidents?”

The purpose of the summary here is to help the client move beyond “poor me” and find ways of coping with this kind of work. The challenge in places like shelters is to create a supportive work environment, develop a sense of organizational and personal purpose, promote the kind of teamwork that fits the institution’s mission, and foster a culture of coping strategies.

**When the client needs a new perspective** Often when scattered elements are brought together, the client sees the “bigger picture” more clearly. In the following example, a man who has been reluctant to go to a counselor with his wife has, in a solo session with the counselor, agreed to a couple of sessions “to please her.” In the session, he talks a great deal of his behavior at home, but in a rather disjointed way.

**COUNSELOR:** I’d like to pull a few things together. You’ve encouraged your wife in her career, especially when things are difficult for her at work. You also encourage her to spend time with her friends as a way of enjoying herself and letting off steam. You also make sure that you spend time with the kids. In fact, time with them is important for you.

**CLIENT:** Yeah. That’s right.

**COUNSELOR:** Also, if I have heard you correctly, you currently take care of the household finances. You are usually the one who accepts or rejects social invitations, because your schedule is tighter than hers. And now you’re about to ask her to move because you can get a better job in Boston.

**CLIENT:** When you put it all together like that, it sounds as if I’m running her life. . . . She never tells me I’m running her life.

**COUNSELOR:** Maybe we could talk a little about this when the three of us get together.

**CLIENT:** Hmm . . . Well, I’d . . . hmm . . . (laughs). I’d better think about all of this before the next session.

The summary provides the client with a mild jolt. He realizes that he needs to face up to the “I am making many decisions for her, and some of them are big” theme implied in the summary. Helping clients develop new perspectives is the focus of Chapter 7.

In the following example, the client is a 52-year-old man who has been talking about a number of problems he is experiencing. He has come for help because he has been “down in the dumps” and cannot seem to shake it.

**HELPER:** Let’s take a look at what we’ve seen so far. You’re down—not just a normal slump; this time it’s hanging on. You worry about your health, but you check out all right physically, so this seems to be more a symptom than a cause of your slump. There are some unresolved issues in your life. One that you seem

to be stressing a lot is the fact that your recent change in jobs has means that you don't see much of your old friends anymore. Because you're single, this leaves you, currently, with a rather bleak social life. Another issue—one you find painful and embarrassing—is your struggle to stay young. You don't like facing the fact that you're getting older. A third issue is the way you—to use your own word—"over invest" yourself in work, so much so that when you finish a long-term project, suddenly your life is empty.

**CLIENT (pauses):** It's painful to hear it all that baldly, but that about sums it up. I've suspected I've got some screwed-up values, but I haven't wanted to stop long enough to take a look at it. Maybe the time has come. I'm hurting enough.

**HELPER:** One way of doing this is by taking a look at what a better future would look like.

**CLIENT:** That sounds interesting, even hopeful. How would we do that?

The counselor's summary hits home—somewhat painfully—and the client draws his own conclusion. Care should be taken not to overwhelm clients with the contents of the summary. And summaries should not be used to "build a case" against a client. Helping is not a judicial procedure. Perhaps the foregoing summary would have been more effective if the helper had also summarized some of the client's strengths. That would have provided a more positive context.

### Get Clients to Provide Summaries

Summaries can be useful when clients do not seem to know where to go next, either in the helping session itself or in a real-world action program. In cases like this helpers can, of course, use probes to help them move on. Summaries, however, have a way of keeping the ball in the client's court. Moreover, the helper does not always have to provide the summary. Often it is better to ask the client to pull together the major points. This helps the client own the helping process, pull together the salient points, and move on. Because this is not meant to test clients, the counselor should provide clients whatever help they need to stitch the summary together.

In another example, the client, who has lost her job and her boyfriend because of her alcohol-induced outbreaks of anger, has been talking about "not being able to stick to the program." The counselor asks her to summarize what she has been doing and the obstacles she has faced. With the help of the counselor, she stumbles through a summary. At the end of it she says, "I guess it's clear to both of us that I haven't been doing a very good job sticking to the program. On paper, my plan looked like a snap. But it seems that I don't live on paper." The client then uses the counselor to help her take a couple of steps back. She begins to review goals, plans, obstacles, and execution.

### Review the Use of Summaries and Probes in the Case of Marcus and Andrea

We share the following example that involves, a helper, Marcus, who is working with a woman, Andrea, a woman with schizophrenia, to demonstrate that

the tenets of this book are applicable in many settings, with a wide variety of individuals. The problem management framework and its components are also useful for those who have significant, complex issues—the power of the basics still apply. Marcus works on an Assertive Community Treatment (ACT) team that is designed to provide comprehensive treatment tailored to individuals with severe mental illness who have significant difficulty with everyday functioning (e.g., obtaining housing, employment, and basic self-care). ACT is designed to help people live independently, to reduce hospital readmission rates, and to simply improve the lives of their clients. Marcus has a caseload and makes home visits, meeting with his clients wherever he can, including in his car.

Marcus's work is challenging. Most of his clients have significant psychotic disorders including schizophrenia. One of his clients, Andrea, has auditory hallucinations that persist despite her medication. Andrea likes Marcus. He listens to her and always does whatever he can to help her manage her life. It took a long time to build their relationship because Andrea's history includes having bad relationships in general, and having mental health professionals who did not care, or even worse, did not treat her as fully human. Marcus does all the right things. As a result, Marcus and Andrea have a good working relationship. Marcus has earned the right to give input, to share his perspective because Andrea knows he will listen and value her input. Although Andrea struggles, she has done better recently than she has in several years. She is now living independently and even has her own apartment. The ACT team and Marcus are part of this success. In the following exchange, he helps Andrea address an issue regarding a recurrent auditory hallucination she is having. She hears a male voice who claims to be a military commander (Andrea briefly served in the military). The voice is telling her to get a grenade to throw into oncoming traffic outside of her house. Marcus uses probes and summarizing as part of a reality testing strategy.

**MARCUS:** Andrea, if you can, give me the details of what you are experiencing.

**ANDREA:** (loudly and fast) I keep hearing this big booming voice tell me to get a grenade and throw it into traffic outside of my apartment. That he is my military commander and that I have to follow orders to protect the infantry. It's freaking me out, it's just not right!

**MARCUS:** (being deliberately calm) I am right here with you. That sounds frightening. Is there anything else you can tell me?

**ANDREA:** (a little calmer but still anxious) His . . . his voice is so scary! I have no idea why he would keep telling me that. He keeps saying I have to "protect the infantry" and that I have to do it "before more die."

**MARCUS:** I wonder what he means when he says he's in the military.

**ANDREA:** He says he is in the Army and that he is a captain. Not sure what else.

In this brief exchange, you can see that Marcus does not directly challenge the reality of what Andrea is sharing. He has learned that doing so shuts down any collaborative work. He is not overly reactive—plus Andrea has never acted on the voices she hears. Instead, he tries to understand without colluding with her. His probes indicate a desire to understand the details of Andrea's hallucination. He



has also learned that by doing this he can often find a piece of information that may not square with Andrea's reality. Marcus also has some military knowledge because his father was in the Army. For instance, he knows that a captain in the Army would not refer to himself as a "military commander." He also knows that Andrea will know that orders must go through a proper chain of command. Will the voice she is hearing know this chain of command? We pick up below with Marcus summarizing their time together after Andrea has taken the conversation off-course to complain about her neighbors. Andrea has a habit of being tangential.

**MARCUS:** Let me stop and interrupt you for a second. No doubt neighbors can be annoying. However, I want to go back and have you help me understand what you told me earlier. During the past week, you have heard, almost every day, a voice ordering you to throw a grenade into traffic. The voice says he is a captain in the Army. I know it is stressful for you to talk about this, but do I have it right?

**ANDREA:** That's right. I don't want to do it, but he won't leave alone and keeps telling me I am costing people their lives.

**MARCUS:** That does sound heavy. Are you hearing his voice right now?

**ANDREA:** Yep . . . I can hardly stand it!

**MARCUS:** I'm sorry, Andrea. But I have an idea. I was wondering though, with your knowledge of the Army, would there be a chain of command for an order such as that?

**ANDREA:** Of course. A captain receives orders like everyone else and on up the chain. Anyone in the military knows this.

**MARCUS:** Do you think this captain knows this, where he got his orders?

**ANDREA:** He has to know.

**MARCUS:** What if he doesn't? Maybe you could ask him.

**ANDREA:** (eyes lighting up) Means he's phony baloney. I am willing to try anything. It is worth a try. (She immediately gets up and walks to a corner of the room and asks him out loud about the chain of command for the order he is giving.)

**MARCUS:** (waits patiently for a few minutes then interjects) Well, did you learn anything?

**ANDREA:** He's a phony. He didn't know squat! I should have known. . . .

**MARCUS:** Known what?

**ANDREA:** Known that it wasn't real. I can just ignore it. Just wish the voice would shut up.

**MARCUS:** That is good to know at least you don't have to listen to it.

They go on to discuss what she learned about this voice. They also discuss ways of telling whether other voices are real or not. Andrea is getting better at this;

she is learning to question the voices. Again, you can see that Marcus uses probes to help Andrea explore opportunities for checking out reality. Marcus does not doubt she is hearing things, but uses probes to help her challenge the authority of these voices. Once she learns that a “voice” is just noise, it loses its power.

**MARCUS:** You’re finding ways of handling these voices, Andrea, aren’t you! You’re learning how to challenge and outsmart them.

**ANDREA:** (Grinning). I am pretty awesome, huh? Hahaha. Couldn’t do it without my shrink though . . . I try to keep learning.

**MARCUS:** You do seem to be learning about yourself. What do you think you have learned?

**ANDREA:** Other than I am awesome? That the things I hear, as scary as they are, I can fight back with my smarts. Just because I hear something doesn’t necessarily mean anything. I don’t have to just freak out. Be calm and come up with a plan.

**MARCUS:** That sounds like real learning!

Marcus used several probes to keep Andrea on-task and moving forward. Probes helped provide Andrea with the structure she needs to describe her experience and tell her story. The summaries also helped keep her see and own her success.

## Come to Grips with the Shadow Side of Communication Skills **L0 6.4**

Up to this point we have been dealing with basic communication skills. In Chapter 7, we will consider advanced communication skills and processes dealing with helping clients move beyond blind spots to the kind of new perspectives that lead to life-enhancing outcomes and the actions needed to get there. But first, let’s look again at the shadow side of communication skills.

### Keep in Mind That Communication Skills Are Necessary but Not Sufficient

Some training programs and helpers tend to overidentify the helping process with communication skills—that is, with communication tools, critical tools though they might be. So being good at communication skills is not the same as being good at helping. Moreover, an overemphasis on communication skills can turn helping into a great deal of talk with very little action—and few outcomes that make a difference in clients’ lives.

Communication skills are essential, of course, but they still must serve both the process and the outcomes of helping. These skills certainly help you establish a good relationship with clients. And a good relationship is the basis for the kind of social-emotional reeducation that has been outlined earlier. But you can be good at communication, good at relationship building, even good at social-emotional reeducation and still shortchange your clients, because they need more than that. Some who overestimate the value of communication skills tend to see a skill such as responding with empathy as some kind of “magic bullet.” Others overestimate the value of information gathering.

On the other hand, it strikes us that the helping professions do not promote the importance of communication skills. Many programs have no courses in communication skills. And we practically never run into research articles on communication skills. This could be related to what is going on in the social media. Communication means smartphones, Facebook, Instagram, and texting. What is happening to face-to-face communication?

### **Distinguish between the Helping Relationship and Helping Technologies**

On the other hand, some practitioners underestimate the need for solid communication skills. There is a subtle assumption that the “technology” of their approach, such as treatment manuals, suffices. They listen and respond through their theories and constructs rather than through their humanity. They become technologists instead of helpers. They are like some medical doctors who become more and more proficient in the use of medical technology and less and less in touch with the humanity of their patients.

Some years ago I (Egan) spent ten days in a hospital (an eternity in these days of managed care). The doctors, nurses, and interns were magnificent in addressing my medical needs. But the psychological needs that sprang from my anxiety about my illness were not addressed at all. Unfortunately, my anxieties were often expressed through physical symptoms. Then those symptoms were treated medically. Out of frustration, I asked the young doctor who was debriefing me about the staffing conference in which my case was reviewed, “When you have conferences during which patients are discussed, do you say, ‘Well, we’ve thoroughly reviewed his medical status and needs. Now let’s turn our attention to what he’s going through. What can we do to help him through this experience?’” The resident said, “No, we don’t have time.” Don’t get me wrong. These were dedicated, generous people who had my physical interests at heart. But they ignored many of my psychological needs. Having healthcare psychologists involved in such staffing sessions is a step in the right direction. I am glad to say that in more recent visits to the same medical center I had startlingly different experiences. It was obvious that the medical profession’s relatively new focus on relationships skills had become part of the center’s culture. Therapy demands both science and art. The helping professions currently focus mostly on science. Art without science is feeble. Science without art is futile.

### **Find Ways of Developing Proficiency in Communication Skills**

Understanding communication skills and how they fit into the helping process is one thing. Becoming proficient in their use is another. Some trainees think that these “soft” skills should be learned easily and fail to put in the kind of hard work and practice that makes them “fluent” in them. Doing the exercises in communication-skills manuals and practicing these skills in training groups can help, but that is not enough to make these skills second nature. The exercises in tuning in, listening, processing, sharing highlights, and probing that are trotted out, as it were, for helping encounters are likely to have a hollow ring to them. These skills must become part of your everyday communication style and stem for a commitment to empathic relationships.

After providing some initial training in communication skills, I tell students, “Now, go out into your real lives and get good at these skills. I can’t do that for you.” In the beginning, it may be difficult to practice all these skills in everyday life, not because they are so difficult, but because they are relatively rare in conversations. Take responding with empathy. Listen to the conversations around you. If you were to use an unobtrusive counter, clicking a button every time you heard someone engage in an empathic response, you might go days without a click. But you can make empathic responding a reality in your own life. And those who interact with you will often notice the difference. They probably will not call it empathy. Rather, they will say such things as “She really listens to me” or “He takes me seriously.”

On the other hand, you will hear many probes, usually in the form of questions, in everyday conversations. People are much more comfortable asking questions than providing understanding. However, many of these probes tend to be aimless. Worse, many will be disguised criticisms. “Why on earth did you do that?” Learning how to integrate purposeful probes with empathy demands practice in everyday life. Life is your lab. Every conversation is an opportunity.

These skills have a place in all the human transactions of life, including business transactions. When businesses are asked what competencies they want to see in job applicants, especially for managerial positions, communication and relationship-building skills are inevitably at or near the top of the list. I once ran a training program on these skills for a CPA firm. Although the director of training believed in their value in the business world, many of the account executives did not. They resisted the whole process. I got a call one day from one of them some months after the training sessions. He had been one of the more notable resisters in one of the training groups. He said, “I owe you this call.” “Really?” I replied with an edge of doubt in my voice. “Really,” he said. He went on to tell me how he had recently called on a potential client, a man whose company was dissatisfied with its current audit firm and looking for a new one. During the interview, the account executive said to himself, “Since we don’t have the slightest chance of getting this account, why don’t I amuse myself by trying these communication skills?” In his phone call to me, he went on to say, “This morning I got a call from that client. He gave us the account, but in doing so he said, ‘You’re not getting the account because you were the low bidder. You were not. You’re getting the account because we thought that you were the only one that really understood our needs.’ So, almost literally, I owe you this call.” I forgot to ask him for a share of the fee.



# Help Clients Challenge Themselves: From New Perspectives to New Behavior

## LEARNING OBJECTIVES

### 7.1 Understand the Basic Concept of Self-Challenge

- Identify the Goals of Challenging
- Help Clients Target Areas for Self-Challenge

### 7.2 Invite Clients to Challenge Their Blind Spots

- Help Clients Identify Different Kinds of Unawareness
- Explore Dysfunctional Awareness: Knowing, but Not Caring

### 7.3 Develop Specific Skills for Helping Clients Challenge Their Blind Spots

- Provide Reality-Based Advanced Empathy When It Adds Value
- Help Clients Get the Information They Need Even When It Is Challenging
- Use Prudent Helper Self-Disclosure, but Sparingly
- Be Careful in Making Suggestions and Giving Recommendations
- Be Slow to Move to Confrontation
- Find Ways to Provide Encouragement

### 7.4 Follow Guidelines for Effective Invitations to Self-Challenge

- Earn the Right to Invite Clients to Challenge Themselves
- Keep the Goals of Invitations to Client Self-Challenge in Mind
- Do Not Force Clients into Decisions, but Do Provide Choice Structure
- Be Tentative but Not Apologetic in the Way You Invite Clients to Self-Challenge
- Help Clients Make Their Self-Challenges Clear and Specific
- Invite Clients to Challenge Unused Strengths Rather than Weaknesses
- Help Clients Build on Their Successes

### 7.5 Avoid Shadow-Side Blocks to Challenge

- Avoid the “Mum Effect”
- Recognize Helper Excuses for Not Inviting Clients to Challenge Themselves

## Understand the Basic Concept of Self-Challenge LO 7.1

Helping is about change and change entails making choices. Chapters 6 and 7 are about helping clients make life-enhancing choices. These chapters present a form of “choice architecture” or structure mentioned in Chapter 6. Inviting clients to challenge themselves in a variety of ways is a stronger form of the kind of “nudging” discussed in that chapter. How do we “frame” therapy in such a way that clients discover and tap into resources within and around themselves? Helping clients place demands on themselves can be one of the most important things helpers can do.

Although little current research on therapy focuses on making choices and **self-challenge**, over the course of history the human race has developed a vast literature dealing with finding and tapping into the best in ourselves—from the Bible to the latest articles on creating a healthy physical, psychological, social, and moral lifestyle for oneself. It would be hubris to think that the human-development wisdom of the ages must now be subjected to randomized clinical trials before it can be incorporated into therapeutic practice. This in no way discounts the value of evidence-based practice. Rather it highlights the need to balance evidence-based practice with the kind of practice-based evidence that has evolved over the centuries.

Life at all levels is full of conflict and conflict involves challenging. In some areas of life, failure to challenge can have devastating consequences. For instance, when nurses and technicians do not challenge mistakes surgeons are making in the operating room, they fail to prevent needless damage to patients, hospitals, and the surgeons themselves. Therefore many hospitals are making concerted efforts to transform the culture of the operating room (Carter, 2006; Landro, 2005) so that no one there need agree with the statement, “In the ORs here, it is difficult to speak up if I perceive a problem with patient care” (Carter, 2006, p. 5). In one survey, 60% of respondents agreed with this statement. Too much is at stake not to challenge.

Helpers can use the communication skills we have reviewed so far to help clients engage in reality testing. Clients who do not know how to engage in self-challenge or who simply do not do it for whatever reason are doing themselves no favor. Reasonable self-challenge is part of maturity. The value of a bias toward action outlined in Chapter 3 demands some form of self-challenge. Consider Belinda, a mother with three young children between 7 and 12. She is seeing a counselor because raising three kids, being a good partner with her husband, tending to a widowed mother with health problems, and holding a very demanding part-time job have become too much for her. She has sleepless nights, blows up at her kids and then indulges them as a way of saying “I’m sorry,” and feels guilty for neglecting her mother. She is especially concerned about her “wild” children and has this to say about her parenting in the second counseling session.

This morning I read an article that struck a very painful chord. It talked about how many middle-class parents raise their kids. On the one hand, they want their kids to be independent and think for themselves, you know, be responsible, but then they do everything for them. And they overprotect them. Gene and I do that and now we



have self-centered kids that expect us to do everything for them. They start nagging me as soon as I get home. Sometimes I begin to think that they don't care about anyone but themselves. And we've done that to them.

Belinda engages in self-challenge. The article she read was very challenging but she was able to recognize herself in it. Rearing her kids lies at the heart of Belinda's problem situation. When she gets home she gets her husband to read the article. He agrees that both of them should attend the counseling sessions.

Such self-initiated self-challenge is ideal, but it is not what usually happens. Because helping at its best is a constructive social-influence process, some form of challenge is central to helping. This does not signal a movement from the pro-client stance taken in this book. Rather it highlights the need for collaboration in making self-challenge part of the helping process. The reality is simple. All effective helping is some kind of mixture of support and challenge. If they are going to manage their problem situation, Belinda and her husband will have to both support and challenge themselves and each other and both support and challenge their kids. Finding the right mixture is essential because challenge without support is harsh, while support without challenge can end up being empty and counterproductive.

Martin (1994) put it well when he suggested that the helping dialogue may add the most value when clients perceive it as relevant, helpful, interested, supportive, and "somehow inconsistent (discordant) with their current theories of themselves and their circumstances" (pp. 53–54). Trevino made the same point (1996) in the context of cross-cultural counseling.

Certain patterns of congruency and discrepancy between client and counselor facilitate change. There is a significant body of research suggesting that congruency between counselor and client enhances the therapeutic relationship, whereas discrepancy between the two facilitates change. In a review of the literature on this topic, Claiborn (1982, p. 446) concluded that the presentation of discrepant points of view contributes to positive outcomes by changing "the way the client construes problems and considers solutions." (p. 203)

Challenge adds that discordant note. Notice that the term challenge rather than the harder-edged confrontation is used here. Most people see both confronting and being confronted as unpleasant experiences. But, at least in principle, they more readily buy the softer but still edgy option of challenge. And self-challenge has an even constructive ring to it. Finn (2005) stresses compassion and firmness, pointing out that at times "we must say difficult things to clients in plain nonjudgmental language, which forces us to develop courage and wisdom" (p. 29). Or perhaps we should say that clients at times "must say difficult things" to themselves. If we help them do so, we are adding value.

Because people make choices based on the beliefs-values-norms-ethics-morality package discussed in Chapter 1, helpers must listen carefully to these drivers of behavior. They must also help clients understand how these drivers are influencing their decisions. It is not that helpers challenge clients' drivers, but they can help clients become aware of these drivers and explore the consequences of their use. Belinda and her husband had, perhaps unknowingly, bought into a philosophy of parenting that proved to have unwanted consequences. Now they want to change their behavior, but they need help in discovering how.

## Identify the Goals of Challenging

The ultimate goal of helping is a set of problem-managing and life-enhancing client outcomes. The overall goal of challenging is to help clients do some reality testing and invest what they learn from this in creating a better future for themselves.

*Help clients challenge themselves to change ways of thinking, expressing emotions, and acting that keep them mired in problem situations and prevent them from identifying and developing opportunities.*

It is especially important to help clients challenge self-defeating *patterns* of thinking, expressing emotion, and behaving (Wei & Ku, 2007). A parallel goal is more upbeat. It deals with new perspectives and translating these new perspectives into new ways of acting. It goes something like this:

*Become partners with your clients in helping them challenge themselves to find opportunities in their problems, to discover unused strengths and resources, both internal and external, and to commit themselves to the actions needed to make opportunity development happen.*

As idealistic as this might sound, it contains the spirit of the counselor's role as "catalyst for a better future."

## Help Clients Target Areas for Self-Challenge

Given the two goals outlined above, some forms of self-challenge involve self-criticism, while others involve self-enhancement. Chang (2007) has edited a book that asks and attempts to answer such questions as follows: Is self-enhancement good or bad? Is self-criticism good or bad? Under what conditions is either of these good or bad? What do helpers do about all of this? It is worth reading before you commit yourself to helping clients challenge themselves.

Counselors should help clients challenge whatever stands in the way of understanding and managing problem situations or identifying and developing life-enhancing opportunities. The following are some of the main targets of self-challenge.

- Self-defeating mind-sets, such as prejudice
- Self-limiting internal behavior, such as dysfunctional daydreaming
- Self-defeating expressions of feelings and emotions, such as flying off the handle
- Dysfunctional external behavior, such as putting people down
- Distorted understanding of what the world is really like
- Discrepancies between thinking and acting
- Unused strengths and resources
- The predictable dishonesties of everyday life

A final category, helping clients challenge themselves to participate fully in the helping process, is discussed later. Here are a few examples in each of these categories.

***Self-defeating mind-sets*** Mind-sets here refer to more or less permanent states of mind. They include such things as assumptions, attitudes, beliefs, values, bias,

convictions, inclinations, norms, outlook, points of view, and perceptions of self/others/the world, preconceptions, and prejudices.

Carlos realizes that Mara has a number of unexplored assumptions, beliefs, and norms that are rooted in the family culture. Even when she talks about her career aspirations, the subtext seems to be that she would like to move ahead to the degree that her family culture would permit such movement. But she never says this directly. Carlos also knows that her personal culture has been influenced by her educational experiences in the United States. Her ambitions, though contained, are typically American. Culturally, she is a hybrid, but Carlos is not sure how these two sets of cultural “voices” play out against each other. It’s not his place to take sides, but he thinks that inviting her to explore her beliefs and assumptions in that regard would help her make decisions in the area of career and in personal relationships. Her painful conversation with her father about her desires to move ahead in the business is a sign that such self-exploration is perhaps overdue.

Mind-sets, whether productive or problematic, tend to drive external behavior—or at least leak out into external behavior. The principle is clear: Invite clients to transform outmoded, self-limiting mind-sets and perspectives into self-enhancing and liberating new perspectives that drive problem-managing and opportunity-developing action. Here are examples dealing with self-limiting beliefs and assumptions.

Albert Ellis (2003, 2004; Ellis & Ellis, 2011) developed a rational-emotional-behavioral approach (REBT) to helping. He claimed that one of the most useful interventions helpers can make is to challenge clients’ irrational and self-defeating beliefs. Clients (and the rest of us) have a way of talking themselves into these dysfunctional beliefs. Some of the common beliefs that Ellis saw as getting in the way of effective living are as follows:

- *Being liked and loved.* I must always be loved and approved by the significant people in my life.
- *Being competent.* I must always, in all situations, demonstrate competence, and I must be both talented and competent in some important area of life.
- *Having one’s own way.* I must have my way, and my plans must always work out.
- *Being hurt.* People who do anything wrong, especially those who harm me, are evil and should be blamed and punished.
- *Being danger-free.* If anything or any situation is dangerous in any way, I must be anxious and upset about it. I should not have to face dangerous situations.
- *Being problemless.* Things should not go wrong in life, and if by chance they do, there should be quick and easy solutions.
- *Being a victim.* Other people and outside forces are responsible for any misery I experience. No one should ever take advantage of me.
- *Avoiding.* It is easier to avoid facing life’s difficulties than to develop self-discipline; making demands of myself should not be necessary.
- *Tyranny of the past.* What I did in the past, and especially what happened to me in the past, determines how I act and feel today.
- *Passivity.* I can be happy by being passive, by being uncommitted, and by just enjoying myself.

I am sure that you could add to the list. Ellis suggested that when these kinds of belief are violated in a person's life, he or she tends to see the experience as terrible, awful, even catastrophic. "People pick on me. I hate it. It shouldn't happen. Isn't it awful!" Such "catastrophizing," Ellis said, gets clients nowhere. It is unfortunate to be picked on, he says, but it is not the end of the world. Moreover, clients can often do something about the issues over which they catastrophize.

Take Allison, a widow in her early 60s, who is seeing a counselor because of "anxiety attacks." A very stressful marriage ended suddenly the previous year when her husband died of a heart attack. At the time she felt angry, guilty, and relieved. She felt guilty because he died at a time when they were having particularly serious disagreements. She wondered whether the arguments had precipitated the attack. But she was also angry because "he left me holding the bag," that is, there was now no way to resolve the conflict. Still she was "profoundly relieved that all of this is over." The relationship together with all its stress was over, she was sure that he was "in a better place," and she was free to redesign her life.

Her current anxiety is due to the fact that she has just had a cancerous intestinal polyp removed. There was no metastasis, so the prognosis is actually quite good. She will have to have tests from time to time to monitor the state of her colon, but she is in no immediate danger. Instead of rejoicing over the good news, she has begun catastrophizing about the things that could go wrong. "These are supposed to be the 'golden years' and now I'm facing the possibility of a deadly disease! And I hate those tests!" Allison is working from the assumption that she should be problemless. "These things shouldn't be happening to me!" The counselor needs to help her challenge her dysfunctional beliefs.

Sternberg (2002, 2003) has explored self-beliefs that make otherwise smart people do stupid things. He has identified four fallacies in the thinking of such people.

- *"The egocentrism fallacy.* They think it's all about them. In planning their actions, they take into account their own interests, but no one else's.
- *The omniscience fallacy.* They may indeed know a lot about something. However, they start to think they know everything about everything.
- *The omnipotence fallacy.* They think that they are all-powerful—that they can do whatever they want.
- *The invulnerability fallacy.* They think that they can get away with whatever they do—that they will not be caught, or that even if they are, they will be able to get themselves out of any fix" (2003, p. 5).

The fact that in politics, the executive suite, the entertainment industry, and sports these blind spots are displayed on the wide screen does not mean that the rest of us are exempt. In fact, no one is exempt.

Riso, du Toit, Stein, and Young (2007) have edited a book that describes the kinds of maladaptive cognitive schemas and core beliefs that characterize a range of psychological disorders. The subtitle of the book, *A Scientist-Practitioner Guide*, seems to stand in contrast to Albert Ellis's commonsense and pragmatic approach to dysfunctional beliefs. The notion of "schemas" which is relatively new, suggests points not just to dysfunctional beliefs but to ingrained systems of thinking that cause trouble. Clients can benefit from identifying and dealing with disordered, self-defeating patterns of thinking. Helping them to do so can add a great deal of value.

**Self-limiting internal behavior** Some forms of thinking are actually behaviors. They are things we can choose to do or not do. Internally we daydream, pray, ruminate on things, believe, identify problems, review opportunities, make decisions, formulate plans, make judgments, question motives, approve of self and others, disapprove of self and others, wonder, value, imagine, ponder, create standards, fashion norms, mull things over, ignore, forgive, rehearse—we do all sorts of things internally. These are internal or cognitive behaviors, not just thoughts or things that happen to us. The helping principle is clear. If clients are to replace self-limiting and self-defeating internal behaviors with more creative ones, they may need some help. The ways in which internal behavior can be self-limiting are legion. Consider a few examples.

John daydreams a lot, seeing himself as some kind of hero whom others admire. Thinking about unrealistic success in his social life has taken the place of working for actual success. The new perspective: Daydreaming is not all that bad. It is how you use it. With the help of a counselor, John does not stop daydreaming, but he switches its focus. He daydreams about what a fuller social life might look like. This provides him with some practical strategies for expanding and enriching his interactions with others. He begins to try these out.

Nadia, when given an assignment on a project, immediately begins to try to think of reasons why the project won't work. Then her internal behavior spills out into external behavior as she goes around telling everyone that the project should be changed or shelved. This annoys her colleagues. With the help of a supervisor, she sees how self-limiting her instinct to take things apart is. She lacks intellectual balance. So her supervisor helps her get into the habit of first trying to see what value the project or program will add to the company and what she might do to improve it. She finds that after doing some of this more positive internal work, she engages her colleagues more constructively about the project. She finds better ways of critiquing projects. They listen to her, and she adds real value.

For some clients, developing new perspectives and changing their internal behavior can be enormously helpful. It certainly works for Bella, a woman whose husband died two years ago. She is suffering from depression, not incapacitating, but still miserable. At one point she says,

**BELLA:** You know, I stopped wearing black a year ago. But. . . (She pauses for a long time.)

**THERAPIST:** But you're still wearing black inside?

In a flash, Bella had it. Not magic, but now she had the metaphor she needed. She knew that she could and should stop wearing black "inside." With just a couple of more sessions with the therapist, Bella begins to move beyond the grieving that had come to be the hallmark of her life.

Carlos notices that Mara has certain ways of thinking that conflict with her desire to create a more satisfying future for herself. She seems to think of herself as the "dutiful daughter" who puts the needs and wants of her parents ahead of her own. This is not the same as being a naturally generous person who readily considers the needs and wants of others and balances them against his or her own needs. If she is to create a more fulfilling future for herself she might benefit from exploring mind-sets such as this.

***Self-defeating expressions of feelings and emotions*** Managing our emotions and the ways we express them is part of social-emotional intelligence. Some of our emotions are bottled up, some go on inside, and others are quite visible. Sheila becomes depressed when her boss fails to notice the good work she is doing. She feels taken for granted. But at work she puts on a good face. On the other hand, Ira rants and raves about his “stupid” boss to whoever will listen. Everyone, except his boss, knows where he stands.

Clients can be helped to face up to needless denial and bottling up of emotions, letting emotions run riot internally, and self-defeating forms of emotional expression. In two studies Berking, Orth, Wupperman, Meier, and Caspar (2008) found, perhaps unsurprisingly, that “a focus on emotion-regulation skills may be important in the prevention and treatment of affect-related mental health problems” (p. 485). The question is: Where do people acquire these skills in the course of growing up? Arthur flies off the handle whenever anyone suggests that a less acerbic interpersonal style would benefit him and his friends, relatives, and colleagues at work. Arthur needs help in seeing the world as others see it. Cynthia lavishes praise on her two children in primary school without exploring the consequences of her behavior. Praising makes her feel good, but what is it doing to her children? She needs to learn that praising is not an unadulterated good. A counselor helps Ken realize that long periods of surfing the Internet tend to trigger episodes of depression. Ken needs to get out and interact with people to maintain emotional balance.

Mara has always presented herself as self-contained, that is, until her disastrous conversation with her father about her job aspirations. Even when she broke down and cried when telling Carlos about the conversations, she kept apologizing for expressing her emotions and made repeated attempts to control herself. Emotional over control may be part of the problem.

***Dysfunctional external behavior*** External behavior is the stuff people could see if they were looking. For some clients, their external behavior constitutes trouble.

- When Achilles is with women at work, he engages in behavior that others, including the courts, see as sexual harassment. He thinks he is just being “friendly.”
- Consider Jake. He is not an alcoholic, but when he has a couple of drinks, he tends to get mean and argumentative. He thinks that he is merely helping others “get the point.” So he would benefit from taking a closer look at both his thinking and his acting.
- Clarence, a self-doubting and overly cautious person, is very deferential around his manager. He does not realize that his manager interprets his deference as a “lack of ambition.” Clarence’s behavior keeps him mired in a job he hates. But the manager says nothing because she would rather have an “obedient” rather than an “aggressive” employee.

Not doing something is also a form of behavior. Clients often fail to make choices and engage in behaviors that would help them cope with problems or develop opportunities. When Clarence is offered an opportunity to update his skills, he turns it down. He also refuses a promotion, saying to himself, “I don’t want



to get in over my head.” His self-defeating external behaviors are based on a self-defeating thought about himself. His manager sees him bypass these opportunities, but says nothing to him. She says to herself, “Anyway, I’ve got a hard-working drone. That’s something these days. I’ll leave well enough alone.”

Ryan is having trouble relating to his college classmates. He is aggressive, hogs conversations, tries to get his own way when events are being planned, and criticizes others freely. One of his friends, after a couple of drinks, gets very angry with Ryan and tells him off. “Self-centered,” “arrogant,” and “pushy,” are the kinds of words she uses. Ryan goes into a funk. Later in the week he talks things through with the dorm prefect, an older student for whom he has a great deal of respect. Ryan begins to see how self-defeating his interpersonal style is. He goes on to work with one of the counselors in the student services center to do something about it. They discuss ways of being proactive and assertive rather than aggressive. His “edge” has too much of an edge about it. He takes a course in interpersonal communication, belatedly learns the value of dialogue, and finds plenty of incentives to invest what he learns in his interactions with his classmates, in his part-time job, and at home.

***Distorted understanding of the world*** Clients’ failure to see the world as it really is can keep them mired in problem situations and prevent them from identifying and developing opportunities. For instance, parents fail to notice signs indicating that their teenage son has started to use drugs. If at times we are blind to others and their needs—often those closest to us—we are also blind to their attitudes toward us and the impact of their behavior on us. Take Sandra. She interprets her husband’s being less insistent when it comes to having sex as a sign that “he is finally coming to his senses.” So she is shocked when she learns, by accident, that he is having an affair. All of us have our areas of ignorance and naiveté. Clients’ failure to fully understand the environment in which they live and the impact it is having on them does not mean that they are stupid. Rather, like all of us, clients fail to notice things that are having a negative impact on their lives.

***Discrepancies*** Various kinds of discrepancies plague our lives. For instance, we do not always do what we say we are going to do. Just review last year’s “New Year’s resolutions.” Discrepancies keep clients mired in their problem situations. Discrepancies can include the following:

- What clients think or feel versus what they say
- What they say versus what they do
- Their views of themselves versus the views that others have of them
- What they are versus what they claim they want to be
- Their stated goals versus what they actually accomplish
- Their expressed values versus their actual behavior

The list goes on. For instance, a helper might help the following clients challenge the discrepancies in their lives.

- Tom sees himself as witty, but his friends see him as biting.
- Minerva says that physical fitness is important, but she overeats and under exercises.



- George says he loves his wife and family, but he is seeing another woman and stays away from home a great deal.
- Clarissa, unemployed for several months, wants a job, but she doesn't want to participate in a retraining program.

Let us use the example of Clarissa to illustrate how the discrepancy between talking and acting can be challenged. Clarissa has just told the counselor that she has decided against joining the retraining program.

**COUNSELOR:** At one time you thought that the retraining program would be just the kind of thing you've been looking for.

**CLARISSA:** Well. . . . I don't know if it's the kind of thing I'd like to do. . . . The work would be so different from my last job. . . . And it's a long program.

**COUNSELOR:** So you feel the fit isn't good.

**CLARISSA:** Yes, that's right.

**COUNSELOR:** Clarissa, I'm curious. You seemed so enthusiastic when you first talked about the program. . . . (gently): What's going on?

**CLARISSA (pauses):** You know, I've gotten a bit lazy. . . . I don't like being out of work, but I've gotten used to it.

The counselor sees a discrepancy between what Clarissa is saying and what she is doing. She is actually letting herself slip into a "culture of unemployment." Now that the discrepancy is out in the open, they can work together on how she wants to shape her future.

**Unused strengths and resources** Clients' self-challenge should focus not just on problems, but also on the "possible self" that every client is. Helping clients get in touch with unexploited opportunities and unused or underused strengths and resources (Aspinwall & Staudinger, 2003; Tedeschi & Kilmer, 2005) can add a great deal of value. Some of these resources are client based—for instance, unused talents and abilities—and some are external—for example, failure to identify and use social support in managing problems or developing opportunities. Therapists can help clients ask themselves questions like this: "What kind of unused strengths do I have? What can I do to unleash and marshal both internal and external resources?" We all have resources we fail to use; they need to be mined.

Strengths are buried even in dysfunctional behavior. For instance, Driscoll (1984) has pointed out that helpers can show clients that even their "irrationalities" can be a source of strength. Instead of forcing clients to see how stupidly they are thinking and acting, therapists can help them find the logic embedded even in seemingly dysfunctional ideas and behaviors. Then clients can use that logic as a resource to manage problem situations instead of perpetuating them. A psychiatrist friend of mine helped a client see the "beauty," as it were, of a very carefully constructed self-defense system. The client, through a series of mental gymnastics and external behaviors, was cocooning himself from real life. My friend helped the client see how inventive he had been and how powerful the system that he had created was.

***The predictable dishonesties of everyday life*** The “predictable dishonesties of life” refers to the distortions, evasions, games, tricks, excuse making, and smoke screens that keep clients (and ourselves) mired in their problem situations. All of us have ways of defending ourselves from ourselves, from others, and from the world. We all have our little dishonesties. But they are two-edged swords. Although lies, whether white or not, may help me cope with difficulties—especially unexpected difficulties—in my interactions with others, they come with a price tag, especially if they become a preferred coping strategy. Blaming others for my misfortunes helps me save face, but it disrupts interpersonal relationships and prevents me from developing a healthy sense of self-responsibility. The purpose of helping clients challenge themselves with respect to the dishonesties of everyday life, whether they take place in the helping sessions or are more widespread patterns of behavior, is not to strip clients of their defenses, which in some cases could be dangerous, but to help them cope with their inner and outer worlds more creatively.

*Distortions.* Some clients would rather not see the world as it is—it is too painful or demanding—and therefore distort it in various ways. The distortions are self-serving. For instance:

- At work Arnie is afraid of his supervisor and therefore sees her as aloof, whereas in reality she is a caring person. He is working out of past fears rather than current realities.
- Edna sees her counselor in some kind of divine role and therefore makes unwarranted demands on him.
- Nancy sees her getting her own way with her friends as an indication of whether they really like her or not.

Let us take a look at Nancy, who is married to Milan. They are experiencing some bumps in their marriage.

Nancy and Milan come from different cultures. They fought a great deal in the early years of their marriage, but then things settled down. Now, squabbles have broken out about the best way to bring up their children. Milan is not convinced that counseling is a good idea, so the counselor is talking to Nancy alone. She has forbidden her 12-year-old son to bicycle to school because she does not want “his picture to end up on a milk carton.” Milan thought that she was being extremely overprotective. One day he stalks out of the house, yelling back at her, “Why don’t you just keep him locked in his room?” Nancy and her counselor have a session not long after the above incident. Nancy is defending her approach to her son.

**NANCY:** Milan’s just too permissive. Now that Jan is entering his teenage years, he needs more guidance, not less. Let’s face it; the world we live in is dangerous.

**COUNSELOR:** So from your point of view, this is not the time for letting your guard down. . . . Of course, I’m also making the assumption that Milan is not indifferent to Jan’s welfare.

**NANCY:** Of course not! Good grief, he cares as much as I do. We just disagree on how to do it. “Safe, not sorry” is my philosophy.

Hopefully, this gets rid of an implied distortion: “I’m interested in my son’s welfare, but his father isn’t.” They continue their dialogue.

**COUNSELOR:** Let’s widen the discussion a bit. What other issues do you and Milan disagree on?

**NANCY:** Well, we used to disagree a lot. But we’ve put that behind us, it would seem. He leaves a lot of the home decisions to me.

**COUNSELOR:** I’m not sure whether you both decided that you should make the decisions at home or if it just happened that way.

**NANCY (slowly):** I suppose it just happened that way. . . . I don’t really know.

**COUNSELOR:** I’m curious because he seems to be annoyed that you’re the one making the decisions about how to bring up your son. . . .

**NANCY (pausing):** Like he wants to reassert himself. Take over again.

Here is another distortion. Perhaps Nancy feels the counselor is getting too close to a sensitive issue that she thought was resolved long ago.

**COUNSELOR:** You got a bit annoyed when I asked whether Milan was as committed to the kids as you. . . . Because he cares as much as you do about his son, I’m wondering what the disagreement is really about.

**NANCY:** Like he’s drawing a line in the sand, taking a stand on this one? Or what?

**COUNSELOR (caringly):** I don’t want to guess what’s going through Milan’s mind. . . . Maybe we could try once more to get him to come with you.

The counselor has a hunch that the problem is as much about power and getting one’s own way as it is about bringing up children. Nancy does seem to have trouble with her own “little dishonesties.”

*Games, tricks, and smoke screens.* If clients are comfortable with their delusions and profit by them, they will obviously try to keep them. If they are rewarded for playing games, inside the counseling sessions or outside, they will continue a game approach to life (see Berne, 1964). Consider some examples:

Kennard plays the “Yes, but. . . .” game. He gets his therapist to recommend some things he might do to control his anger. He then points out why each recommendation will not work. When the therapist calls this game, Kennard says, “Well, I didn’t think you guys were supposed to tell clients what to do.” A savvy helper might have sniffed out Kennard’s tendency to play games much earlier.

Dora makes herself appear helpless and needy when she is with her friends, but when they come to her aid, she is angry with them for treating her like a child. When she tries this in an early session, her counselor invites her to examine this “helpless and needy” routine.

The number of games we can play to avoid the work involved in squarely facing the tasks of life is endless. Clients who are fearful of changing will attempt to lay down smoke screens to hide from the helper the ways in which they fail to face up to life. Such clients use communication in order not to communicate.

Therefore helpers do well if they establish an atmosphere that discourages clients from playing games.

*Excuses.* Snyder, Higgins, and Stucky (1983) examined excuse-making behavior in depth. Excuse making, of course, is universal, part of the fabric of everyday life (see also Halleck, 1988; Higginson, 1999; Snyder & Higgins, 1988; Yun, 1998). Like games and distortions, it has its positive uses in life. Even if it were possible, there is no real reason for setting up a world without myths. On the other hand, excuse making contributes a great deal to avoiding the problems of life. Clients, like the rest of us, routinely provide excuses for why they did something “bad,” why they did not do something “good,” and why they cannot do something they need to do.

For example, Roberto tells the helper that he has engaged in benign attempts to sabotage his wife’s career “for her own good” because she would “get hurt” in the Anglo world. The counselor helps him explore the alternative hypothesis that “he is not ready” for the changes in style that his wife’s career and behavior were demanding from him.

Before Roberto and Maria got married, they talked a great deal about the cultural difficulties they might face. He tended to adhere to traditional Latino culture, whereas she was much more open to what he saw as “Anglo” attitudes and behavior. For instance, she was especially concerned about cultural norms relating to the role of women in society. When asked about their differences, Roberto said he would enjoy being married to someone with a “pioneer” spirit. Maria said that she thought that they had “worked things out.” That was then. Now she has put herself through college, gotten a job, developed it into a career, and assumed the role of both mother and co-breadwinner. She makes more money than Roberto. His woes include thinking that he is losing face in the community, feeling belittled by his wife’s success, and being forced into an overly “democratic” marriage.

If Roberto is going to manage the conflict between himself and his wife better, he needs to challenge himself to review and make changes in some of the ways he thinks.

This only skims the surface of the games, evasions, tricks, distortions, excuses, rationalizations, and subterfuges resorted to by clients (together with the rest of the population). Skilled helpers are caring and empathic, but they do not let themselves be conned. That helps no one.

In practice, these targets for challenge are often mixed together. Take Minerva who is depressed because of the lack of a social life. Because of a few traumatic past experiences, she believes that the world is filled with dishonest people (a self-limiting mind-set). Whenever she meets someone new, she views that person’s behavior through this lens and thinks that he or she is guilty until proved innocent (internal behavior in need of reform). Because she is always on guard, she comes across as cold and indifferent (inadequate management of feelings and emotions). Therefore, when she meets someone new, she is defensive and often questions that person’s intentions and actions (external behavior needing change). She also realizes that when she meets someone new, she expects some kind of initial trust on the part of the other person even though she does not give it herself (a discrepancy). She looks for flaws in other people’s character and when she finds them she pounces on them (a self-defeating game). She fails to see

that even her closest friends are becoming uncomfortable around her (failure to see the world as it really is). In the counseling sessions, Minerva remains guarded and is slow to share what she really thinks (inadequate participation). To make things worse, Minerva does not seem to have a clue that this is what she is doing.

This section ends with a caution from Steven Hayes (2005, 2007, 2008; Bach & Moran, 2008; Dewane, 2008; Luoma, Hayes, & Walser, 2007; Sisemore, 2017) related to the pervasiveness of self-defeating thoughts and emotions. In an approach to helping he calls “acceptance and commitment therapy” (ACT), he invites clients to step back from their endless war with “bad” thoughts and feelings. Do not waste time and energy avoiding or confronting them. Rather embrace and defuse them with “respectful attention.” Change your *relationship* with bad thoughts and feelings.

For example, instead of disputing negative thoughts, patients learn to watch them mindfully and at enough distance to realize, in a visceral and not just analytical way, that they’re just thoughts. Instead of getting rid of sadness, patients learn to detect how sadness feels in their body, how it tugs at their behavior, how it ebbs and flows, and begin to feel at a deep level that they can carry sorrow with them while still living the life they want. (2007, p. 48)

But then what? Hayes next helps clients determine what they want to live for and, in light of a focused sense of purpose, how they want to live. Befriending troublesome thoughts and feelings clears the way for the real work of life. As counselors, “we . . . can help our clients gain access to their deepest aspirations and turn a life lived in the present moment into a life *worth* living” (2007, p. 52). Therefore ACT is a mildly directive approach to counseling. ACT therapist help clients place demands on themselves to reconstruct their lives. Hayes has written extensively about the research behind his approach.

## Invite Clients to Challenge Their Blind Spots **LO 7.2**

Up to this point the discussion has focused on what needs to be challenged, the content, as it were. However, it is also necessary to consider the client’s degree of awareness of self-limiting thinking, emotional expression, and behavior. Like the rest of us, clients do not always realize, or realize fully, how they are limiting themselves. That is, they have **blind spots**. Blind spots are part of the human condition (Banaji & Greenwald, 2013). They are things we fail to see or choose to ignore that keep us from identifying and managing problem situations or identifying and developing opportunities. Van Hecke (2007) explores ten common blind spots that get people in trouble—failure to think things through, always having the right answers, failure to pick up cues and clues and notice what is going on, lack of self-awareness, failure to explore one’s biases, seeing the world through rigid categories, jumping to conclusions, failure to check things out, seeing coincidences as causes, and failure to see the big picture and put things in context. She suggests that, while we readily see others’ blind spots and the “stupidities” they lead to, we remain ignorant of our own: “When *others* seem dense to us, whatever we grasp seems so clear that we cannot fathom how they could have missed it” (p. 19). So our clients might well be quite perceptive when

it comes to others but need help to sharpen their perceptions of themselves. Blind spots are obstacles to effective decision-making.

### **Help Clients Identify Different Kinds of Unawareness**

Some blind spots appear to be unintentional, whereas others tend to be self-inflicted. Either way, they stand in the way of change. Blind spots come in a variety of flavors.

**Simple unawareness** Some things clients are simply not aware of. Becoming aware of them helps them know themselves better and both cope with problems and develop opportunities. Serge was surprised when a fellow member of a self-help group called him “talented.” He was brought up in a family that prized modesty and “humility.” He never thought about himself as talented, creative, or resourceful and had little idea how this lack of awareness had narrowed his life. His mind-set stood in the way of change. Katya, on the other hand, was always upbeat. Because she always tried to look at the positive side of things, she “exuded sunshine,” as one of her friends put it. What she did not realize was that sometimes her exuberance was inappropriate because it stood in the way of facing problems squarely. One of her colleagues at work thought that Katya’s upbeat nature was great but needed to be tempered by a dose of reality.

Katya had two friends, Mia and Casper. Mia had her own problems. For instance, she thought that her emotional outbursts were part of her punchy style. She did not realize that sometimes her colleagues at work wanted to strangle her. Casper didn’t know that he had an acerbic communication style. If asked, he would describe himself as “assertive” and “logical.” The problem is that his “assertiveness” made people shy away from him. And others around him saw his “logic” as stubbornness. People avoided or ignored him. No wonder he was dissatisfied with his social life.

Simple unawareness is itself an elastic term. There are degrees. At one end is simple ignorance—“He doesn’t have a clue.” At the other end the ignorance is not so simple. Mia said of Casper, “He probably has some idea that he’s rubbing people the wrong way; he’s not totally in the dark.

**Failure to think things through** This is a very common human experience. We explore problems, examine opportunities, search for possibilities, or formulate plans of action in an incomplete and haphazard way. Then we go on to base decisions on our flawed reasoning.

Kim and Lea are both women who have lost a son in Iraq. They have long been both neighbors and friends, but recently have had some bitter encounters. Kim believes that the war was a mistake and that her son has died because of the “politicians,” whereas Lea believes that the war was essential for national security and that her son has died fighting for a very just cause. Their beliefs are so charged with emotion that neither has any feeling for the other’s point of view. They are both so set in their convictions that they are willing to destroy their relationship, something that neither son would have wanted.

In this case, strong convictions made stronger by emotion keep them from thinking things through. In other cases, habit or laziness or thoughtlessness is the



villain. Counselors who challenge and help clients think key issues through provide an invaluable service.

Failure to explore the possible short- and long-term consequences of a dysfunctional pattern of behavior is an all too common human experience. One client, let us call him Clancy, knew that he could get into trouble if he hung around a group of classmates who forgot about limits when they went out together “to have a good time.” His mother cautioned him a number of times, but really did not know the full extent of the emerging problem. Individually you would see them as “good kids” more or less, but when they got together for “enjoyment” a dysfunctional kind of “group think” and “group act” took over. At the beginning of one holiday weekend his mother cautioned him not to go out of town with his buddies and not to drink. He went out of town with them, got drunk, rubbished a hotel, “pushed” a police officer, and ended up in the hospital, being given two years of probation by a judge, and expelled from his private high school—a life in shambles. It took one or two more incidents to bring him to his senses and, with a help of a counselor very familiar with stories like Clancy’s, he began to put his life back together. He is in pretty good shape now. A failure to see the consequences of dysfunctional behavior messed up his life. Or did it teach him an invaluable life lesson?

**Self-deception** Where does simple lack of awareness or failure to think things through end and self-deception start? There are things clients would rather not know, because, if they knew them, they would be challenged to change their behavior in some way. So they would rather stay in the dark. Goleman, who has written extensively about social and emotional intelligence, early on wrote a book called *Vital Lies, Simple Truths* (1985) on the psychology of self-deception and its pervasiveness in human life. Self-deception and the kind of social-emotional maturity outlined in his book *Emotional Intelligence* are incompatible.

Yet, as Eduardo Giannetti (1997) points out in *Lies We Live By: The Art of Self-Deception*, it is ubiquitous. “How,” he marvels, “do we carry out such feats as believing in what we do not believe in, lying to ourselves and believing the lie . . . ?” (p. viii). Stan thought that he could get away with flirting with other women even though he was engaged. “It’s just natural for a man,” was his excuse. His fiancée saw his behavior as insulting. When she called off the wedding, Stan painfully realized the price of his self-deception.

**Choosing to stay in the dark** Choosing to stay in the dark is a common human experience. It is as if someone were to say, “I could find out, but I don’t want to, at least not yet.” Heffernan (2011) calls this “willful blindness”:

We make ourselves powerless when we choose not to know. But we give ourselves hope when we insist on looking. The very fact that willful blindness is willed, that it is a product of a rich mix of experience, knowledge, thinking, neurons, and neuroses, is what gives us the capacity to change it. (p. 247)

Lots of people, when they have physical symptoms such as pain in their guts, avoid thinking about it. This can be a life-threatening decision. Finding out



whether the pain indicates something serious could be uncomfortable or even intolerable. Like the rest of us, clients often enough choose to stay in the dark.

Ilia, recently released from jail, knows that she should have a clear understanding of the conditions of her probation, but chooses not to. When asked about the conditions, she says, “I don’t know. No one really explained them to me.” She knows that if she gets caught violating any of the conditions, she could go back to jail. But she puts that out of her mind.

When clients are being vague or evasive with their helpers, they may also be keeping something from themselves, something that would hurt to know or know more fully.

### **Explore Dysfunctional Awareness: Knowing, but Not Caring**

Clients sometimes know that their thinking, forms of emotional expression, and acting are getting them into trouble or keeping them there, but they do not seem to care. We can use the term blind spot, at least in an extended sense, to describe this kind of behavior because clients do not seem to fully understand or appreciate the degree to which they are choosing their own misery. Or they do not see the implications and consequences of not caring. Think of Clancy. Or consider Tanel. Tanel tells a counselor that he knows nagging his wife to get a job even though there are two young children at home annoys his wife, but he keeps on anyway. “I can’t help it.” This creates a great deal of tension, but he continues to focus on his wife’s reluctance to get a job rather than the negative consequences of his nagging. He has some idea of the pool of resentment that is building in his wife, but he persists. This case has not been resolved. How would you proceed with Tanel?

So, as you can see, the term blind spot as used here is somewhat elastic. We are unaware, we deceive ourselves, we do not want to know, or we ignore, we do not care, or we know, but not fully; that is, we do not fully understand the implications or the consequences of what we know. But it is a good term. It has great face validity. As soon as you say “blind spot,” people generally know what you mean.

Helping clients deal with blind spots is one of the most important things you can do as a helper. For instance, if Lester has a prejudice and does not advert to it, he has a blind spot. If he has a prejudice but adverts to it only vaguely (though he probably does not refer to his attitude as a prejudice), then he is keeping himself in the dark. If he knows he is prejudiced and, when asked, says, “Everyone I know is like that!” then he does not care and fails to explore the human meaning of prejudice. He is prejudiced, knows it, fosters it, and lets it spill over into the way he deals with people. Lester has the full dysfunctional package.

Contrast this with Bernice. Initially she is unaware that she is prejudiced, becomes aware of her prejudice, tries to get rid of it as part of her internal mental furniture, refuses to act on it, and even learns something about herself and the world as she does all this. She deals with her prejudice creatively. She has turned a problem into an opportunity. Helping clients deal with dysfunctional blind spots can prevent damage, limit damage already done, and turn problems into opportunities. Box 7.1 outlines the kinds of questions you can help clients ask

**BOX 7.1**    **Questions to Uncover Blind Spots**

These are the kinds of questions you can help clients ask themselves in order to develop new perspectives, change internal behavior, and change external behavior.

- What problems am I avoiding?
- What opportunities am I ignoring?
- What's really going on?
- What am I overlooking?
- What do I refuse to see?
- What don't I want to do?
- What unverified assumptions am I making?
- What am I failing to factor in?
- How am I being dishonest with myself?
- What's underneath the rocks?
- If others were honest with me, what would they tell me?

themselves in order to surface blind spots and develop new perspectives. In therapy new perspectives are often called insights. Insight in the helping professions has a long and somewhat problematic history. The main challenge for helpers is this: How can therapists help clients turn insight into life-enhancing action?

## **Develop Specific Skills for Helping Clients Challenge Their Blind Spots**    **LO 7.3**

Self-challenge focuses on the kind of understanding that leads to constructive action together with the constructive action itself. We do our clients a disservice if all that we do is help them identify and explore self-limiting blind spots. The upbeat part of self-challenge is helping clients transform blind spots into new perspectives and translate these new perspectives into more constructive patterns of both internal and external behavior.

There are many upbeat names for this process of transforming blind spots into new perspectives: seeing things more clearly, getting the picture, getting insights, developing new perspectives, spelling out implications, transforming perceptions, developing new frames of reference, looking for meaning, shifting perceptions, seeing the bigger picture, developing different angles, seeing things in context, context breaking, rethinking, getting a more objective view, interpreting, overcoming blind spots, second-level learning, double-loop learning (Argyris, 1999), thinking creatively, reconceptualizing, discovering, having an “ah-ha” experience, developing a new outlook, questioning assumptions, getting rid of distortions, relabeling, and making connections. Some terms used to describe this process are frame breaking, frame bending, and reframing. You get the idea. All of these imply some kind of cognitive restructuring that is needed in order to identify and manage both problems and opportunities. Developing new perspectives, although painful at times, tends to be ultimately prized by clients.

One way of helping clients challenge both internal and external actions is to help them explore the consequences of their actions. Let us return to Roberto. He has made some “mild” attempts at sabotaging his wife’s career. He refers to his actions as “delaying tactics.”

**HELPER:** It might be helpful to see where all of this is leading.

**ROBERTO:** What do you mean?

**HELPER:** I mean let’s review what impact your “delaying tactics” have had on Maria and your marriage. And then let’s review where these tactics are most likely ultimately to lead.

**ROBERTO:** Well, I can tell you one thing. She’s become even more stubborn.

Through their discussion, Roberto discovers that his sabotage is working against rather than for him. He is endangering the marriage by keeping himself in the dark.

Effective helpers assume that clients have the resources to see themselves and the world in which they live in a less distorted way and to act on what they see. Another way of putting it is that skilled counselors help clients move from what the Alcoholics Anonymous movement calls “stinkin’ thinkin’” to healthy thinking. And from “stinkin’” emoting to constructive emotional expression. And from dysfunctional actions to healthy behavior. Consider Carla. Facing menopause, she is lumbered with the outmoded view of menopause as a “deficiency disease.” Without minimizing Carla’s discomfort and stress, a counselor helps her see menopause as a natural developmental stage of life. Although it indicates the ending of one phase, it also opens up new life-stage possibilities. Looking forward to those possibilities rather than looking back at what she has lost helps Carla a great deal.

There are many ways in which counselors can help clients engage in the kind of self-challenge that leads to perspectives that can help them change their behavior, both internal and external. Some invitations to self-challenge tend toward the indirect end of the continuum, while others are more direct. Let us start with some indirect approaches: **advanced empathy**, that is, identifying and sharing the message behind the message, sharing information, and helper **self-disclosure**.

### **Provide Reality-Based Advanced Empathy When It Adds Value**

Recall the quote from Carl Rogers mentioned in Chapter 5. He said that empathy sometimes involves sensing meanings of which the client is scarcely aware. This is the fuller message or the message behind the message. I call sharing this added meaning “advanced” empathy. For instance, Gordon gets angry when he talks about his interactions with his ex-wife, but as he talks, the helper hears not just anger but also hurt. It may be that Gordon can talk relatively easily about and express his anger but is reluctant to talk about his feelings of hurt. When you respond with basic empathy—provided, of course, that you are accurate—clients recognize themselves almost immediately: “Yes, that is what I meant.” However, because responding with empathy to messages that are more covert (advanced empathy) digs a bit deeper, clients might not immediately recognize themselves in

your response. And so they might experience a bit of disequilibrium. That is what makes advanced empathy a form of challenge. It invites clients to take a closer look at themselves and their behavior. For instance, the helper says something like this to Gordon: “It’s pretty obvious that you really get steamed when she acts like that. . . . But I thought I sensed, mixed in with the anger, a bit of hurt.” At that, Gordon looks down and pauses. He finally says, “She can still get to me. She certainly can.” This appreciably broadens or deepens the discussion of the problem situation.

Here are some questions helpers can ask themselves to probe a bit deeper as they listen to clients.

- What is this person only half saying?
- What is this person hinting at?
- What is this person saying in a confused way?
- What covert message is behind the explicit message?

Note that advanced empathic listening and processing focuses on what the client is actually saying or at least expressing, however tentatively or confusedly. That is, it is not an interpretation of what the client is saying. Sharing advanced highlights is not an attempt to “psych the client out.”

In the hands of skilled helpers, capturing and sharing the message behind the message focuses not just on the problematic dimensions of clients’ thinking, emotional expression, and behavior, but also on unused opportunities and resources. Effective helpers listen for the resources that are buried deeply in clients and often have been forgotten by them. Consider the following example. The client, a soldier who has been thinking seriously about making the army his career, has been talking to a chaplain about his failing to be promoted. He has performed well in both Iraq and Afghanistan. As he talks, it becomes fairly evident that part of the problem is that he is so quiet and unassuming that it is easy for his superiors to ignore him.

**SOLDIER:** I don’t know what’s going on. I work hard, but I keep getting passed over when promotion time comes along. I think I work as hard as anyone else, and I work efficiently, but all of my efforts seem to go down the drain. I’m not as flashy as some others, but I’m just as substantial.

**CHAPLAIN A:** You feel it’s quite unfair to do the kind of work that merits a promotion and still not get it.

**SOLDIER:** Yeah, I suppose there’s nothing I can do but wait it out. (A long silence ensues.)

Chaplain A tries to understand the client from the client’s frame of reference. He deals with the client’s feelings and the experience underlying those feelings. He responds with basic empathy. But the client merely retreats more into himself. Here is a different approach.

**CHAPLAIN B:** It’s depressing to put out so much effort and still get passed by. . . . Tell me more about this “not as flashy bit.” I’m curious. I wonder whether there is something in your style that might make it easy for others not to notice you, even when you’re doing a good job.

**SOLDIER:** You mean I'm so unassuming that I could get lost in the shuffle? Or maybe it's the guys who make more noise, the squeaky wheels, who get noticed. . . . I guess I've never really thought of selling myself. That's not my style.

From the context, from the discussion of the problem situation, from the client's manner and tone of voice, Chaplain B picks up a theme that the client states in passing in the phrase "not as flashy." They go on to discuss how he might "market himself" in a way that is consistent with his values. Advanced empathy can take a number of forms. Here are some of them.

**Help clients make the implied explicit** The most basic form of advanced empathy involves helping clients give fuller expression to what they are implying rather than saying directly. In the following example, the client has been discussing ways of getting back in touch with his wife after a recent divorce, but when he speaks about doing so, he expresses very little enthusiasm.

**CLIENT (somewhat hesitatingly):** I could wait to hear from her. But I suppose there's nothing wrong with calling her up and asking her how she's getting along.

**COUNSELOR A:** It seems that there's nothing wrong with taking the initiative to contact her. After all, you'd like to find out if she's doing okay.

**CLIENT (somewhat drearily):** Yeah, I suppose I could.

Counselor A's response might have been fine at an earlier stage of the helping process, but it misses the mark here, and the client does not move on.

**COUNSELOR B:** You've been talking about getting in touch with her, but, unless I'm mistaken, I don't hear a great deal of enthusiasm in your voice.

**CLIENT:** To be honest, I don't really want to talk to her. But I feel guilty—guilty about the divorce, guilty about her going out on her own. Frankly, all I'm doing is trying to take care of her all over again. And that's one of the reasons we got divorced. I had a need to take care of her, and she let me do it, even though she resented it. That was the story of our marriage. I don't want to do that anymore.

**COUNSELOR B:** What would a better way of going about all this be?

**CLIENT:** I need to get on with my life and let her get on with hers. Neither of us is helpless. (His voice brightens.) For instance, I've been thinking of quitting my job and starting a business with a friend of mine—helping small businesses to start their own business-oriented social networks. I think there's a great opportunity there.

Counselor B bases her response not only on the client's immediately preceding remark but also on the entire context of his story. Her response hits the mark, and the client moves forward. As with basic empathic highlights, there is no such thing as a good advanced highlight in itself. Does the response help the client clarify the issue more fully so that he might begin to see the need to act differently?

**Help clients identify themes in their stories** When clients tell their stories, certain themes emerge. Thematic material might refer to feelings (such as hurt, depression, and anxiety), thoughts (continually ruminating about a past mistake), behavior (controlling others, avoiding intimacy, blaming others, and overwork), experiences (being a victim; being seduced, punished, ignored, or picked on), or some combination of these. Once you see a self-defeating theme or pattern emerging from your discussions, you can share your perception and help the client check it out.

In the following example, a counseling-psychology trainee is talking with his supervisor. The trainee has four clients. In the past week, he has seen each of them for the third time. This dialogue takes place in the middle of a supervisory session.

**SUPERVISOR:** You've had a third session with each of four clients this past week.

Even though you're at different stages with each because each started in a different place, you have a feeling, if I understand what you've been saying, that you're going around in circles with a couple of them.

**TRAINEE:** Yes, I'm grinding my wheels. I don't have a sense of movement.

**SUPERVISOR:** Any thoughts on what's going on?

**TRAINEE:** Well, they seem willing enough. And I think I've been very good at listening and sharing highlights. It keeps them talking.

**SUPERVISOR:** But this doesn't seem to be enough to get them moving forward.

I tell you what. Let's listen to one of the tapes.

They listen to a segment of one of the sessions. The trainee turns off the recorder.

**TRAINEE:** Oh, now I see what I'm doing! It's all basic empathy with a few uh-huhs. And all the time I thought I was being pushy. But when I listen to the tape I realize I'm about as far from pushy as you can get.

**SUPERVISOR:** So what's missing?

**TRAINEE:** There are very few probes and nothing close to summaries or mild invitations to self-challenge. Certainly some probes would have given much more focus and direction to the session.

**SUPERVISOR:** Let me role-play the client as well as I can and see how you might redo the session.

They then spend about 15 minutes in a role-playing session. The trainee mingles some probes with basic highlights, and the result is quite different.

**SUPERVISOR:** How close did you get to challenging, even mild challenging?

**TRAINEE:** I didn't get there at all. You know, I think that I see probes as invitations to self-challenge. And they are, at least to some degree. The thread through all of this is "playing it safe." I think I'm playing it safe because I don't want to damage the client. I'm afraid to push.

The theme that the supervisor helps the trainee surface is a fear of "being pushy," which explains his "playing it safe" behavior.

**Help clients make connections that may be missing** Clients often tell their stories in terms of experiences, thoughts, behaviors, and emotions in a hit-or-miss way. The counselor's job, then, is to help them make the kinds of connections that provide insights or perspectives that enable them to move forward.

- Her counselor helps Chu Hua see that she is having difficulty developing strategies for her chosen goals because she is only half-heartedly committed to her goals. They revisit the goals she has set for herself to see how realistic they are.
- Owen says he has a “problem with” pornography. He avoids the word “addiction.” He says that his wife has found out and is very unhappy with his behavior. When asked to describe his concern more fully he launches into a whole range of excuses as to why such behavior is not that bad at all. His therapist gives a brief summary of what Owen has been saying, then adds, “So I’m not sure whether you’re saying that it’s really your wife who has the problem.” Owen pauses for a while, then says, “You know if the roles were reversed, if she was the one who was addicting herself to porn, I’d be made as mad as hell. He pauses again, and the therapist says, “Well, let’s start over.” Wiping the therapy slate clean helps Owen a great deal. He begins to explore the implications of his addiction to porn.
- A therapist helps Joanna see the link between her ingratiating style and her inability to influence her colleagues at work.
- A supervisor helps Dieter, who works with an NGO on poverty issues in Kenya, see that the persistent anxiety he feels when working with tribal leaders is related to the perfectionist standards he constantly sets for himself, standards that are out of place in the Kenyan culture.

The following client, John, has a full-time job and is finishing the final two courses for his college degree. His father has recently had a stroke and is incapacitated. John talks about being progressively more anxious and tired in recent weeks. He visits his father regularly. He meets frequently with his mother, his two sisters, and his two brothers to discuss how to manage the family crisis. Under stress, fault lines in family relationships appear. John does his best to be the peacemaker. He has deadlines for turning in papers for current courses.

**JOHN:** I don’t know why I’m so tired all the time. And edgy. I’m supposed to be the calm one. I wonder if it’s something physical. You know, what’s happened to Dad and all that. I never even think about my health.

**COUNSELOR:** A lot has happened in the past few weeks. Work. School. Your dad’s stroke. Juggling schedules.

**JOHN (interrupting):** But that’s what I’m good at. Working hard. Juggling schedules. I do that all the time. And I don’t get tired and edgy.

**COUNSELOR:** Add in your dad’s illness. . . .

**JOHN:** You know, I could handle that, too. If I were the only one, you know, just mom, and me I bet I could do it.



**COUNSELOR:** All right, so besides you dad's illness, what's different?

**JOHN (slowly):** Well, I hate to say it. It's the squabbling. We usually get on pretty well. We all like getting together. But the meetings about Dad, they can be awful. I keep thinking about them at work. And the other evening when I was trying to write a paper for school, I was still ticked off at my older sister.

**COUNSELOR:** So the family stuff is really a big deal and it's getting to you.

**JOHN:** I'm just not used to all that. I thought we'd rally together. You know, get support from one another. Sometimes it's just the opposite.

John handles the normal stress of everyday life quite well. But the "family stuff" is acting like a multiplier. They go on to discuss what the family dynamics are like and what John can do to cope with them.

**Share educated hunches based on empathic understanding** As you listen to clients, thoughtfully process what they say, and put it all into context, you will naturally begin to form hunches about the message behind the message or the story behind the story. You can share the hunches that you feel might add value. The more mature and socially competent you become and the more experience you have helping others, the more "educated" your hunches become. Here are some examples.

- *Helping clients see the bigger picture.* Hunches can help clients see the bigger picture. In the following example, the counselor is talking with a client who is having trouble with his perfectionism. He also mentions problems with his brother-in-law, whom his wife enjoys having over. He and his brother-in-law argue, and sometimes the arguments have an edge to them. At one point the client describes him as "a guy who can never get anything right." Later the counselor says, "We started out by talking about perfectionism in terms of the inordinate demands you place on yourself. I wonder whether it could be 'spreading' a bit. You should be perfect. But so should everyone else." They go on to discuss the ways his perfectionism may be interfering with his social life.
- *Helping clients go a bit deeper.* Hunches can help clients see more clearly what they are expressing indirectly or merely implying. In this next example, the counselor is talking to a client who feels that a friend has let her down: "I think I might also be hearing you say that you are more than disappointed—perhaps even betrayed." Because the client has been making every effort to avoid her friend, "betrayal" rings truer than "let down." She gets in touch with the depth of her feelings.
- *Helping clients see implications and draw conclusions.* Hunches can help clients draw logical conclusions from what they are saying. A manager is having a discussion with one of his team members who has expressed in a rather tentative way some reservations about one of the team's projects. At one point the manager says, "If I stitch together everything that you've said about the project, it sounds as if you are saying that it was ill-advised in the first place and probably should be shut down. I know that might sound

drastic and you've never put it in those words. But if that's how you feel, we should discuss it in more detail."

- *Helping clients open up.* Hunches can help clients open up areas they are only hinting at. In this case, a school counselor is talking to a senior in high school: "You've brought up sexual matters a number of times, but you haven't pursued them. My guess is that sex is a pretty important area for you but perhaps pretty sensitive, too."
- *Helping clients see things they may be overlooking.* A counselor is talking to a client who probably has only six months to live. The man is unmarried and has never made a will. He has some money, but has expressed indifference to money matters. "I'm financially lazy" is his theme. He adds, "I'm ready to die." Later in the session, the counselor says, "I wonder if your financial laziness has spread a bit. For instance, you live alone and, if I'm not mistaken, you haven't given anyone power of attorney in health matters either. That could mean that how you die will be in the hands of the doctors." This helps the client begin to rethink how he wants to die. They even discuss finances. He may not be a slave to money, but whatever money he has could go to a good cause.
- *Helping clients own their stories.* Hunches can help clients take fuller ownership of partially owned experiences, behaviors, feelings, points of view, and decisions. For example, a counselor is talking to a client who is experiencing a lot of pain in a physical rehabilitation program following an automobile accident. She keeps focusing on how difficult the program is. At one point the counselor says, "You sound as if you have already decided to quit. Or I might be overstating the case. . . ." This helps the client enormously. She has been thinking of quitting but she has been afraid to discuss it. They go on to discuss her wanting to give up and her dread of giving up. When the counselor finds out that she has never even mentioned the pain to the members of the rehabilitation staff, they discuss strategies for coping with the pain, including direct conversations with the staff about the pain.

Like all responses, hunches should be based on your understanding of your clients. If your clients were to ask you where your hunches come from—"What makes you think that?"—you should be able to identify the experiential and behavioral clues on which they are based. Of course, responding with empathy is not a license to draw inferences from clients' history, experiences, or behavior at will. Nor is it a license to load clients with interpretations that are more deeply rooted in your favorite psychological theories than in the realities of the client's world. Constructive advanced empathy requires emotional intelligence and social competence on your part.

In two different articles, Neukrug and his associates (Neukrug, Bayne, Dean-Nganga, & Pusateri, 2013; Neukrug, 2017) offer and give examples of some advanced empathy suggestions under the title of "creative and novel approaches to empathy." Some of these we have seen or will see in one form or another, such as reflecting deeper feelings, pointing out discrepancies, helper self-disclosure, reflecting nonverbal behaviors, and pointing out conflictual feelings and thoughts. But others, such as using visual imagery, analogies, metaphors,

referring to media like movies, books, or stories, reflecting tactile responses, and referring to clients' historical and cultural narratives are "creative and novel." I would suggest reading both articles to see what might fit with your own helping style. We certainly agree with Neukrug's (2017) conclusion: "My experience has been that when one becomes expert at basic empathy . . . and has some understanding of creative and novel approaches, then these advanced responses will become a natural part of the counselor's repertoire" (p. 45). The most important question is: To what degree do they help the client move forward?

### **Help Clients Get the Information They Need Even When It Is Challenging**

Sometimes clients are unable to explore their problems fully, set goals, and proceed to action because they lack information of one kind or another. Information can help clients at any stage of the helping process. Early on therapy helps some clients to know that they are not the first to try to cope with a particular problem. Later on information can help them further clarify possibilities and set goals. In the implementation stage, information on commonly experienced obstacles can help clients cope and persevere.

The skill or strategy of information sharing is included under challenging skills because it helps clients develop new perspectives on their problems or shows them how to act. It includes both providing new information and correcting misinformation. In some cases, the information can prove to be quite confirming and supportive. For instance, a parent who feels responsible following the death of a newborn baby may experience some relief through an understanding of the earmarks of the sudden infant death syndrome. This information does not "solve" the problem, but the parent's new perspective can help him or her handle self-blame.

In some cases, the new perspectives clients gain from information sharing can be both comforting and painful. Consider the following example.

Adrian was a college student of modest intellectual means. He made it through school because he worked very hard. In his senior year, he learned that a number of his friends were going on to graduate school. He, too, applied to a number of graduate programs in psychology. He came to see a counselor in the student services center after being rejected by all the schools to which he had applied. In the interview, it soon became clear to the counselor that Adrian thought that many, perhaps even most, college students went on to graduate school. After all, most of his closest friends had been accepted in one graduate school or another. The counselor shared with him the statistics of what could be called the educational pyramid—the decreasing percentage of students attending school at higher levels. Adrian did not realize that just finishing college made him part of an elite group. Nor was he completely aware of the extremely competitive nature of the graduate psychology programs to which he had applied. He found much of this relieving but then found himself suddenly faced with what to do now that he was finishing school. Up to this point he had not thought much about it. He felt disconcerted by the sudden need to look at the world of work.

Giving information is especially useful when lack of accurate information either is one of the principal causes of a problem situation or is making an existing problem worse.

In some medical settings, doctors team up with counselors to give clients messages that are hard to hear and to provide them with information needed to make difficult decisions. For instance, Doug, a 71-year-old accountant, has been given a series of diagnostic tests for possible prostate cancer. He finds out that he does have cancer, but now he faces the formidable task of choosing what to do about it. The doctor sits down with him and lays out the alternatives. Because there are many different options, including doing nothing, the doctor also describes the pluses and minuses of each. Later Doug has a discussion with a counselor who helps Doug cope with the news, process the information, and begin the process of making a decision.

It is one thing just not having useful or even essential information. It is quite another thing to avoid information. Information avoidance, sometimes called strategic ignorance, is quite common in everyday life (Bernstein, 2017; Sweeny, Melnyk, Miller, & Shepperd, 2014). “We avoid looking at our bank accounts after paying the bills, resist stepping on a scale after the holidays, refuse to schedule preventive health tests” (p. A9). We all say that we have set of “good” values, but few of us explore how well we put these values into practice. Our clients can be particularly susceptible to information avoidance (Howell & Shepperd, 2012, 2013a, 2013b, 2015, 2017). Helping our clients avoid strategic ignorance is certainly on the self-challenge menu.

There are some cautions helpers should observe in both giving information and helping clients explore areas of strategic ignorance. When information is challenging, or even shocking, be tactful and help the client handle the disequilibrium that comes with the news. Do not overwhelm the client with information. Make sure that the information you provide is clear and relevant to the client’s problem situation. Don’t let the client go away with a misunderstanding of the information. Be supportive; help the client process the information. Finally, be sure not to confuse information giving with advice giving. Professional guidance is not to be confused with telling clients what to do. Neither the doctor nor the counselor tells Doug which treatment to choose. But Doug needs help with the burden of choosing.

### **Use Prudent Helper Self-Disclosure, but Sparingly**

Another route to helping clients challenge themselves involves your ability and willingness to share some of your own experiences, thoughts, behaviors, and feelings with clients. The ups and down of helper self-disclosure has been explored thoroughly (Barnett, 2011; Farber, 2006; Forrest, 2010; Henretty & Levitt, 2010; Kelly & Rodriguez, 2007; Myers & Hayes, 2006; Veach, 2011; Yeh & Hayes, 2011; Zur, Williams, Lehavot, & Knapp, 2009; Ziv-Beiman & Shahar, 2016). However, there is no single voice as to its value, its limitations, and its dangers in therapy. In one sense counselors cannot help but disclose themselves: “The counselor communicates his or her characteristics to the client in every look, movement, emotional response, and sound, as well as with every word” (Strong & Claiborne, 1982, p. 173). This is the kind of indirect disclosure that goes on all the time. Effective helpers, as they tune in, listen, process, and respond, try to track and manage the impressions they are making on clients.

Here, however, it is a question of direct self-disclosure. Research into direct helper self-disclosure has led to mixed and even contradictory conclusions. Henretty and Levitt (2010) in one of the most detailed reviews of the research say

that the problem starts with the definition of therapist self-disclosure: “Multiple definitions of therapist self-disclosure render meaningful analysis of findings across studies difficult, if not impossible” (p. 69). Therefore we can expect to run across contradictory findings. Some researchers have discovered that helper self-disclosure can frighten clients or make them see helpers as less well adjusted. Or, instead of helping, helper self-disclosure might place a further burden on clients. Other studies have suggested that clients appreciate helper self-disclosure. Some clients see self-disclosing helpers as “down-to-earth” and “honest.”

Direct self-disclosure on the part of helpers can serve as a form of modeling. Self-help groups such as Alcoholics Anonymous and other drug treatment programs use such modeling extensively. Some would say that helper self-disclosure is most appropriate in such settings. This helps new members get an idea of what to talk about and find the courage to do so. It is the group’s way of saying, “You can talk here without being judged and getting hurt.”

Beth is a counselor in a drug rehabilitation program. She herself was a substance abuser for a number of years but, with the help of the agency where she is now a counselor, she is clean and sober. It is clear to all people with addictions in the program that the counselors there were once substance abusers themselves and are not only rehabilitated but also intensely interested in helping others both rid themselves of drugs and develop a kind of lifestyle that helps them stay drug-free. Beth freely shares her experience, both of being a drug user and of her rather agonizing journey to freedom, whenever she thinks that doing so can help a client.

Other things being equal, counselors who have struggled with addictions themselves often make excellent helpers in programs like this. They know from the inside the games clients afflicted with addictions play. Sharing their experience is central to their style of counseling and is accepted by their clients. It helps clients develop both new perspectives and new possibilities for action. Such self-disclosure is challenging. It puts pressure on clients to talk about themselves more openly or in a more focused way.

Helper self-disclosure is challenging for at least two reasons. First, it is a form of intimacy and, for some clients, intimacy is not easy to handle. Therefore helpers need to know precisely why they are divulging information about themselves. Second, the message to the client is, indirectly, a challenging “You can do it, too,” because revelations on the part of helpers, even when they deal with past failures, often center on problem situations they have overcome or opportunities they have seized. However, done well, such disclosures can be very encouraging for clients.

In the following example, the helper, Rick has had a number of sessions with Tim, a client who has had a rather tumultuous adolescence. For instance, he fell into the “wrong crowd” and got into trouble with the police a few times. His parents were shocked, and his relationship with them became very strained. Rick believes it will be helpful to share some of his own experiences.

**RICK:** You know, Tim, I’ve had experiences like yours. It might be helpful to compare notes. In my junior year in high school I was expelled for stealing. I thought that it was the end of the world. My Catholic family took it as the ultimate disgrace. We even moved to a different neighborhood in the city.

**TIM:** What did it do to you?

Rick briefly tells his story, one that includes setbacks not unlike Tim's. But Rick, with the help of a very wise and understanding uncle, was able to put the past behind him. He does not over dramatize the events. In fact, his story makes it clear that developmental crises are normal. How people interpret and manage them is the critical issue.

Current research does not give us definitive answers about helper self-disclosure, but it does offer some commonsense guidelines. Because clients sometimes misinterpret helpers' self-disclosures and their intent, caution is in order. Here are some guidelines.

***Make sure that your disclosures are appropriate*** Sharing yourself is appropriate if it helps clients achieve treatment goals. Do not disclose more than is necessary. Helper self-disclosure that is exhibitionistic is obviously inappropriate. Jeffrey (2004) provides us some outrageous examples of inappropriate self-disclosure. One helper discussed her own problems with the father-daughter bond, her guilt at disapproving a parent, personal religious issues, and her love life. The client switched to a therapist who said nothing about herself. Helper self-disclosure should be a natural part of the helping process, not a gambit. Rick's self-disclosure helps give Tim a different view of the "bad things" that have happened. Rick's developmental perspective gives Tim a different lens, a new way of looking at his problem. But Rick also makes it clear that he is not trying to make excuses for Tim's behavior.

***Make sure that disclosures are culturally appropriate*** (Barnett, 2011; Burkard et al., 2006; Kim et al., 2003). Helper behaviors do not automatically transfer from one culture to another. For instance, Carlos is hesitant to talk about some of his dual-cultural experiences because he sees that Mara's Iranian culture is far different from his Latin background. Many of her experiences have been negative whereas most of his experiences have been positive. His Hispanic parents urged him to integrate with mainstream American culture. He spoke Spanish at home and had a deep appreciation of Latin culture. He had integrated the two cultures well. So he presented himself as Carlos, a person very content with his dual-heritage background.

***Be careful of your timing*** Timing is critical. Common sense tells us that premature or poorly timed helper self-disclosure can distract clients or turn them off. Rick's disclosures did not take place in the first meeting. He waited for a few sessions. However, once he saw a natural opening, he thought that sharing some of his own experiences would help. Experience teaches you what "natural openings" look like.

***Keep your disclosure selective and focused*** Do not distract clients with rambling stories about yourself. In the following example, the helper is talking to a first-year graduate student in a clinical-psychology program. The client is discouraged and depressed by the amount of work he has to do. The counselor wants to help him by sharing his own experience of graduate school.

**COUNSELOR:** Listening to you brings me right back to my own days in graduate school. I don't think that I was ever busier in my life. I also believe that the most depressing moments of my life took place then. On any number of occasions, I wanted to throw in the towel. I remember once toward the end of my third year when. . . .



It may be that selective bits of this counselor's experience in graduate school would be useful, but he wanders off into a kind of reminiscing that meets his needs rather than the client's. In contrast, Rick's disclosure was selective and focused.

***Do not disclose too frequently*** Helper self-disclosure is inappropriate if it occurs too frequently. When helpers disclose themselves too frequently, clients may see them as self-centered, phony, or immature. Or they may suspect that they have hidden motives. If Rick had continued to share his experiences whenever he saw a parallel with Tim's, Tim might have wondered who was helper and who was client.

***Do not burden the client*** Do not burden an already overburdened client. One novice helper thought that he would help make a client who was sharing some sexual problems more comfortable by sharing some of his own sexual experiences. After all, he saw his own sexual development as not too different from the client's. However, the client reacted by saying: "Hey, don't tell me your problems. I'm having a hard enough time dealing with my own." This novice counselor shared too much of himself too soon. He was caught up in his own willingness to disclose rather than its potential usefulness to the client. In more extreme cases intimate disclosure might appear to be seductive. As Ziv-Beiman and Shahar (2016) put it, your clients should not "react" to your disclosure; rather they should in some way "emerge."

***Remain flexible*** Take each client separately. Adapt your disclosures to differences in clients and situations. When asked directly, clients say that they want helpers to disclose themselves (see Handpick, 1988), but this does not mean that every client in every situation wants it or would benefit from it. Even though Rick's disclosure to Tim was natural, it was a thoughtful decision on Rick's part.

Reviewers of Faber's (2006) book on self-disclosure in psychotherapy (Hamilton, Del Castillo, & Stiles, 2007) end by saying that the "reader comes away with the sense of having absorbed a great deal of information, yet (appropriately, in our view) having few definitive answers" (p. 362). Henretty and Levitt's (2010) extensive review of the research comes to the same conclusion. The broad principles and cautions outlined here will have to do for now, and, given the complexity of human nature, perhaps forever.

Now we turn to more direct approaches to challenge. Client self-responsibility is a key value in helping. Therefore some version of Thaler and Sunstein's (2008) "libertarian paternalism" is in order in just about every form of challenge. However, while some challenges are more direct than others, they still leave decision-making where it belongs—in the hands of the client. Here are a few more direct approaches to client self-challenge.

### **Be Careful in Making Suggestions and Giving Recommendations**

This section begins with a few libertarian imperatives. Do not tell clients what to do. Do not try to take over their lives. Let clients make their own decisions. All these imperatives flow from the values of respect and empowerment. Does this mean, however, that suggestions and recommendations are forbidden? Of course



not. Some clients, more in some cultures than in others, expect or want explicit guidance. And guidance can be given in ways that do not rob the client of self-responsibility. As mentioned earlier, there is a natural tension between helpers' desire to have their clients manage their lives better and respecting their freedom. If helpers build strong, respectful relationships with their clients, then stronger and more direct interventions can make sense. In this context, suggestions and recommendations can stimulate clients to move to problem-managing action. Helpers move from counseling mode to guidance role. Research has shown that clients will generally go along with recommendations from helpers when the recommendations are clearly related to the problem situation, challenge clients' strengths, and are not too difficult. Effective helpers can provide suggestions, recommendations, and even directives without robbing clients of their autonomy or their integrity.

Here is a classic example of this from Cummings's (1979, 2000) work. Substance abusers came to him because they were hurting in many ways. He used every communication skill available to listen to and understand their plight.

During the first half of the first session the therapist must listen very intently. Then, somewhere in mid-session, using all the rigorous training, therapeutic acumen, and the third, fourth, fifth, and sixth ears, the therapist discerns some unresolved wish, some long-gone dream that is still residing deep in that human being, and then the therapist pulls it out and ignites the client with a desire to somehow look at that dream again. This is not easy, because if the right nerve is not touched, the therapist loses the client. (1979, p. 1123)

Cummings discovered that the desire for a better life was there, however faint or deeply buried, in most of his clients. So he shared both basic and advanced empathic highlights to let clients know that he understood their plight, their longings, but also their games. They came knowing how to play every game in the book. But Cummings knew all the games, too. Toward the end of the first session he told them they could have a second session—which they invariably wanted—only when they were “clean.” That is, the time of the second session depended on the withdrawal period for the kind of substance they were abusing. They screamed, shouted “foul,” tried to play games, but he remained adamant. The directive “Get clean, then return” was part of the therapeutic process. And most did return. Clean. Is this approach right for everyone? No approach is.

Suggestions, advice, and directives need not always be taken literally. They can act as stimuli to get clients to come up with their own package. One client said something like this to her helper: “You told me to let my teenage son have his say instead of constantly interrupting and arguing with him. What I did was make a contract with him. I told him that I would listen carefully to what he said and even summarize it and give it back to him. But he had to do the same for me. That has produced some useful monologues. But we avoid our usual shouting matches. My hope is to find a way to turn it into dialogue.” In everyday life, people feel free to give one another advice. It goes on all the time. But helpers must proceed with caution. Suggestions, advice, and directives are not for novices. It takes a great deal of experience with clients and a great deal of savvy to know when they might work.

## Be Slow to Move to Confrontation

What about clients who keep dragging their feet and therefore keeping themselves mired in their problem situations? Some clients who do not want to change or do not want to pay the price of changing simply terminate the helping relationship. However, those who stay stretch across a continuum from mildly to extremely reluctant and resistant (reluctance and resistance are taken up in Chapter 8. Or they may be collaborative on some issues but reluctant on others. For instance, Hester is quite willing to work on career development but very reluctant to work on improving interpersonal and work relationships, even though relationship building is an important part of the career package. Here is part of the dialogue with her coach:

**HESTER:** Relationships? That's my private world. I deal with those privately.

**COUNSELOR:** I'm not sure whether you're saying that your relationships, whether personal or work related, don't have an impact on your work and your career.

**HESTER:** I'm not saying that. It's just nobody else's business.

**COUNSELOR:** And the forum in which you deal with relationship style and problems and the impact they have on your life?

**HESTER:** I take care of that inside my head.

**COUNSELOR:** Well, that could mean that we are at a standstill in our conversation.

**HESTER:** Why is that?

They go on to have a discussion about how making critical issues off limits affects a therapeutic dialogue.

If inviting clients to challenge themselves is at one end of the continuum, what is at the other? Where does respecting clients' right to be themselves stop and placing demands on them to live more fully begin? Because this is a values issue, different helpers give different answers. As a consequence, helpers differ, both theoretically and personally, in their willingness to confront. For instance, Lowenstein (1993) used what he called "traumatic confrontation" (one wonders about the name) to challenge youths to face up to their dysfunctional behavior. He gives the example of confronting a 12-year-old boy who had become involved in criminal activity after the disappearance of his father. At first the boy denied everything, but then decided to face up to the situation.

Patterson, Grenny, McMillian, and Switzer (2011) suggest that "crucial confrontations" are called for when people fail to live up to clear and realistic expectations that have been set up with them or for them: "To confront means to hold someone accountable face to face" (p. 4). People who break promises, violate expectations, or engage in bad behavior should expect to be confronted. In counseling, confrontation focuses on the failure of someone to live up to his or her own expectations or the legitimate expectations of the culture or community, however defined, in which the person lives.

Helpers confront to "make the case" for more effective living. Confrontation does not involve "do this or else" ultimatums. More often it is a way of

making sure that clients understand what it means not to change—that is, making sure they understand the consequences of persisting in dysfunctional patterns of behavior or the cost of failing to seize opportunities. Confrontation, like strong medicine, is actually another way of caring for the client. But, like strong medicine, it needs to be used sparingly and carefully. Confrontation should be empathic and respectful, empower the client, and lead to action. Helpers should not use confrontation to vent their frustrations on reluctant and resistant clients.

### Find Ways to Provide Encouragement

This section ends on a more positive note. If the whole purpose of challenging is to help client move forward, and if encouragement (sugar) works as well as challenge (vinegar), then why do not we hear more about encouragement? The sugar-vinegar analogy is not exactly right, however, because many clients find invitations to self-challenge both refreshing and stimulating. Challenge certainly does not preclude encouragement. Encouragement itself is a mild form of challenge. It is a nudge. Furthermore, encouragement is a form of support, and research shows that support is one of the main ingredients in successful therapy.

Rollnick and Miller (1995) introduced an approach to helping called “motivational interviewing” (Arkowitz & Westra, 2008; Miller & Rollnick, 1995, 2002, 2004; Michael, Curtin, Kirkley, Jones, & Harris, 2006; Moyers, Miller, & Hendrickson, 2005; Rollnick, Miller, & Butler, 2012; Rosengren, 2009). Their original work focused on helping clients deal with addictive behavior, but their methodology over the years has been adapted to a much wider range of human problems. Much of the literature highlights the main elements of a problem-management approach.

Motivational interviewing is a directive, person-centered clinical method for helping clients resolve ambivalence and move ahead with change. It can be applied as a preparation for treatment, a freestanding brief intervention, an enduring clinical style, or a fallback approach when motivational obstacles are encountered. (Miller & Rollnick, 2004, p. 299)

As such, it can be used at any stage or for any task in the problem-management framework. The values of respect, empathy, self-empowerment, and self-healing are emphasized.

Because “informing” clients about such things as the consequences of their behavior is part of the motivational interviewing approach, it is an admittedly directive approach with a light touch. The spirit of encouragement rather than confrontation pervades the approach. Typically, clients (for instance, pregnant women who smoke or use alcohol) receive personal feedback on their problem area (such as how smoking has been affecting their lungs and the harm smoking and drinking can cause the fetus). There are discussions of personal responsibility and advice on ways of managing the problem situation is offered. Clients are encouraged to find the motives, incentives, or levers of change that make sense to them and to use the change options that they find fit best. Intrinsic motives, that is, motives that clients have internalized for themselves (“I want to be free”), rather than extrinsic motives (“I’ll get in trouble if I don’t change”) are emphasized. Clients are also given help on identifying obstacles to change and ways of

**BOX 7.2    The Wisdom of Challenging**

How well do I do each of the following as I try to help my clients?

- Invite clients to challenge themselves.
- Earn the right to challenge.
- Be tactful and tentative in challenging without being insipid or apologetic.
- Help clients develop specific self-challenges that hit the mark and make a difference.
- Help clients challenge their strengths rather than their weaknesses.
- Make sure that self-challenge does not become self-demeaning or self-destructive.
- Invite clients to clarify and act on their own values.

overcoming them. Empathy, both as a value and as a form of communication (empathic responses), is used extensively. Self-determination is at the heart of motivational interviewing (Vansteenkiste & Sheldon, 2006).

Common sense suggests that realistic encouragement be included among any set of helping skills. Like most of the skills we have been discussing, encouragement can be used at any stage of the helping process. Clients can be encouraged to identify and talk about their problems and unused opportunities, to review possibilities for a better future, to set goals, to engage in actions that will help them achieve their goals, and to overcome the inevitable obstacles. Effective encouragement is not patronizing. It is not the same as sympathy, nor does it rob the client of autonomy. It respects the client's self-healing abilities. It is a fully human nudge in the right direction.

Box 7.2 focuses on how well you help clients challenge themselves. Can you add a few questions to the list?

## **Follow Guidelines for Effective Invitations to Self-Challenge**    LO 7.4

Your invitations to self-challenge might be on the mark (smart) and still be ineffective or even hurtful. All invitations should be permeated by the spirit of the client-helper relationship values discussed in Chapter 3; that is, they should be based on understanding of the client (not favorite theories), caring (not power games or put-downs), genuine (not tricks or games), and designed both to increase the client's self-responsibility (not expressions of helper control) and to help the client move into outcome-focused action (not endless discussions). Empathy should permeate every invitation to self-challenge. Respect for the client's values is paramount. Clearly, inviting clients to self-challenge is not a skill that comes automatically. Helpers use all the communication and relationship-building skills already discussed in Part II of this book. The following helper self-challenge principles constitute some basic guidelines for making the self-challenge invitations to clients discussed earlier not just accurate but wise.

## Earn the Right to Invite Clients to Challenge Themselves

Long ago Berenson and Mitchell (1974) claimed that some helpers do not have the right to invite clients to challenge themselves because they are not doing a good job keeping their own houses in order. They made a point worth exploring and also debating because it raises issues implied in the question, “Is helping a profession or a vocation?” Here are some of the factors that earn you the right to invite clients to challenge themselves.

***First, develop a solid relationship*** Challenge only after you have spent time and effort building a relationship with your client. If your rapport is poor or you have allowed your relationship with the client to stagnate, then challenge yourself to deal with the relationship more creatively. Invitations should spring from empathy. Effective challenge flows from accurate understanding. Only when you see the world through clients’ eyes can you begin to see how their thinking, behaving, and emotional expressions are getting them into trouble and keeping them there. Empathy is not an amenity; it should give substance to every helper response.

***Be open to invitations to challenge from others*** Hesitate to invite others if you deal poorly with the expressed or implied invitations others make to you both in counseling sessions and in everyday life. If you are defensive in the counseling relationship, in your relationship with supervisors, or in your everyday life, your invitations might ring hollow. Model the kind of non-defensive attitudes and behavior that would like to see in your clients. Chris, a politically and socially conservative helper, has a liberal-minded brother in another city. They do not see each other that often, but their phone conversations almost inevitably end in acrimony. Chris is capable of being empathic, but his preference for debate too often intervenes.

***Work on your own life*** How important is constructive change in your own life? Berenson and Mitchell claimed that only people who are striving to live fully according to their value system have the right to invite others to challenge themselves, for only such persons are potential sources of human nourishment for others. Perhaps we as helpers should ask ourselves such questions as, “Why should others accept invitations to self-challenge from me? What remains unchanged in my own life?”

You may disagree with any of the points Berenson and Mitchell make, but then you must still determine what gives you the right to invite clients to challenge themselves. If your approach to helping avoids challenge of any kind, then, while you may avoid conflict, you end up with a different kind of problem.

I have used the conservative-versus-liberal situation in one of the examples. Do not get me wrong. I am not choosing liberalism over conservatism or vice versa. The highly diverse world in which we live offers us all sorts of conflicting philosophies, political systems, points of view, values, attitudes, and approaches to ethics and morality. So, how well do you deal with diversity without surrendering your own values in both your professional and everyday life?

## Keep the Goals of Invitations to Client Self-Challenge in Mind

Invitations to self-challenge must be integrated into the entire helping process. Keep in mind that the goal is to help clients develop the kinds of alternative perspectives, internal behavior, and external actions needed to achieve the three general outcomes discussed in Chapter 1. Of course, counselors need to help clients personalize these broad outcomes. Life-enhancing client outcomes remain the bottom line of helping, but the client has to discover and buy into any given set of outcomes.

Chris, the therapist mentioned earlier, tends to invite his clients to challenge both thinking and behaving that is at odds with *his* values and principles. At times he moves beyond invitations to outright confrontation. He says to one young client, Serena, a drug user who has moved back home: “You are probably not aware that you are operating out of a self-defeating philosophy. It seems to me that you are saying to yourself, however unconsciously, something like this: ‘I can do anything I want, but if I get into trouble, then you [that is, society] have to take care of me.’ If this is the case, you’re always going to be at odds with your parents, yourself, and society as a whole.” Fine, perhaps—if this were a conversation between friends. But Chris is a helper, not a friend. What he says may even be true, but shoving the truth down clients’ throats usually leads nowhere. He *can* help Serena discover her philosophy of life and then explore the consequences, especially the unintended consequences, of that philosophy. He can even say, “Serena, our philosophies of life are so different that I am probably not the best therapist for you.” Helping sessions are not the place to proselytize.

## Do Not Force Clients into Decisions, but Do Provide Choice Structure

Remember that providing choice architecture or structure (discussed in Chapter 6) does not force clients into any given decision. Rather it helps clients see things in a different light and give them the freedom to make decisions that they otherwise would not have made (Corsini, 2011; Hagedorn, 2011). In the following excerpt, the counselor is talking to a man who has discussed at length his son’s ingratitude. Talking about his complaints has been cathartic for him, but it is time to move on.

**COUNSELOR:** People often have blind spots in their relationships with others, especially in close relationships. Picture your son sitting with some counselor. He is talking about his relationship with you. What’s he saying?

**CLIENT:** Well, I don’t know. . . . I guess I don’t think about that very much. Hmm. . . . He’d probably say . . . well, that he loves me. . . . And then he might say that since his mother died, I have never really let him be himself. I’ve done too much to influence the direction of his life rather than let him fashion it the way he wanted. . . . Hmm. He’d say that he loves me but he has always resented my “interference.”

**COUNSELOR:** So both love for you and resentment for all that control.

**CLIENT:** And he’d be right. I’m still doing it. Only occasionally with him. He won’t let me. He’s on to my game. But I’m learning a couple of things.

Being pushy is just part of my style. I do it instinctively. I'm just beginning to realize the negative impact it has at work. But I'm not sure that I'm ever going to change.

The counselor provides a choice structure (suggesting that the client “walk” a bit in his son’s shoes) that enables the client to challenge himself with respect to his controlling dysfunctional aspects of his interpersonal style. He is just beginning to come to grips with the untended negative consequences of that style. Would that all clients would respond so easily! Alternatively, the counselor might have asked this client to list three things he thinks he does right and three things he thinks he should reconsider in his relationship with his son. The point is to be inventive with the probes and choice structures you provide clients to help them challenge themselves.

### **Be Tentative but Not Apologetic in the Way You Invite Clients to Self-Challenge**

Tentative invitations are generally viewed more positively than strong, direct challenges. The principle is this: When your invitations are tentative, clients are more likely to respond rather than react. Deliver invitations as hunches that are open to review and discussion. If your invitations sound like accusations, your clients will react accordingly. Inviting clients to self-challenge is certainly not an opportunity to put clients in their place.

On the other hand, invitations delivered with too many qualifications—either verbally or through the helper’s tone of voice—sound apologetic and can be easily dismissed by clients. I was once working in a career-development center. As I listened to one of the clients, it soon became evident that one reason he was getting nowhere was that he was full of self-pity. When I shared this observation with him, I over qualified it. These are not my exact words, but it must have sounded something like this:

**EGAN:** Has it ever, at least in some small way, struck you that one possible reason for not getting ahead, at least as much as you would like, could be that at times you tend to engage in a little bit of self-pity?

I still remember his response. He paused, looked me in the eye for what seemed to be an eternity, and said slowly, “A little bit of self-pity?” When he paused again, I said to myself, “I’ve been too harsh!” He continued, “I *wallow* in self-pity.” He was waiting for the invitation. We moved on to explore what he might do to move beyond self-pity to constructive change.

### **Help Clients Make Their Self-Challenges Clear and Specific**

Inviting clients to challenge themselves on specific issues tends to hit the mark. Vague challenges get lost. Clients do not know what to do about them. Statements such as “You need to pull yourself together and get on with it” might satisfy some helper need, such as the ventilation of frustration, but they do little for clients. Specific statements, on the other hand, can hit the mark. In the following example, the client is experiencing a great deal of stress both at home and at work.



**HELPER:** You say that you really want to spend more time at home with the kids and you really enjoy it when you do, but you keep taking on new assignments at work, like the Eclipse project, that will add to your travel schedule. Maybe it would be helpful to talk a bit more about work-life balance.

**CLIENT:** Boy, there's that phrase! Work-life balance. The company talks a lot about it, but nothing much happens. I'm not sure there's anyone at work who's got the work-life balance right.

**HELPER:** You know what they say about career—"If you're not in charge of your career, no one is." I wonder if this may also be true with work-life balance.

**CLIENT:** I hadn't thought about it like that. . . . But I'm afraid you might be right. I've been waiting for my family and my company to figure it out for me. Very few of us do much to *seize* the right balance.

They go on to discuss the specifics that the client would like to see in the work-life balance package. Some helpers avoid clarity and specificity because they feel that they are being too intrusive. Often helping has to be intrusive to make a difference.

### **Invite Clients to Challenge Unused Strengths Rather than Weaknesses**

Many researchers in the positive psychology movement mentioned in Chapter 1 found that successful helpers tend to challenge clients' unused or underused strengths rather than their weaknesses. In this regard the positive psychology movement's emphasis on strengths (Dahlsgaard, Peterson, & Seligman, 2005; Peterson & Seligman, 2004; Lopez, 2008; Wong, 2006) is just catching up to what Berenson and Mitchell said long ago. People who focus too much on their failures find it difficult to change their behavior. Everyone talks about learning from their mistakes, but how many do? When people dwell too much on their shortcomings, they tend to belittle their achievements and withhold rewards from themselves even when they engage in life-enhancing behavior.

Challenging strengths means helping clients explore the assets and resources they have but fail to use. In the following example, the helper is having a one-to-one session with a woman who is a member of a self-help group in a rape crisis center. She is very good at helping others but too often is down on herself.

**COUNSELOR:** Ann, in the group sessions, you provide a great deal of support for the other women. You have an amazing ability to spot a person in trouble and provide an encouraging word. And when one of the women wants to give up, you are the first to invite her to review her decision. You do it gently and forcibly at the same time. But when Ann is dealing with Ann. . . .

**ANN:** I know where you're headed. . . . I know I'm a better giver than receiver. I'm much better at caring than being cared about. I'm not sure why that is. . . . Or that it even matters. I'm sure this is not lost on the other members of the group. . . . This is the way I am. And have been for a long time. I think I've got some bad habits when it comes to dealing with myself. I'm so fearful of being self-indulgent.

The counselor helps her place a demand on herself to use her rather substantial resources in her dealings with herself. Because she is not self-indulgent, it is time to help her take a look at her resistance to being cared about.

Even adverse life experiences can be a source of strength. The name for this phenomenon is posttraumatic growth (Cole, 2015; *Economist*, July 23, 2016; McGonigal, 2016; Rendon, 2015). Park, Lechner, Antoni, and Stanton (2009) have edited a book that explores how medical illness can lead to positive life change. McMillen, Zuravin, and Rideout (1995) studied adult perceptions of benefit from child sexual abuse. Almost half the adults reported some kind of benefit, including increased knowledge of child sexual abuse, protecting other children from abuse, learning how to protect themselves from others, and developing a strong personality—without, of course, discounting the horror of the abuse. While stigma is an obstacle to such growth in persons with HIV, social support can lead to growth (Zeligman, Barden, & Hagedorn, 2016). Counselors, therefore, can help clients “mine” benefits from adverse experiences, putting to practical use the age-old dictum that “good things can come from evil things.” People (including clients) are often more resilient than we make them out to be.

### Help Clients Build on Their Successes

Effective helpers do not urge clients to place too many demands on themselves all at once. Rather, they help clients place reasonable demands on themselves and, in the process, help them appreciate and celebrate their successes. In the following example, the client, Anan, a student from the Middle East who has just finished a degree in business, is talking with a counselor in the university placement center. As a student, Anan always undersold himself and his achievements. The truth is that he has been an excellent student and deals with people very well. The only one he seems to be down on is himself. After each success in school, he brightened up but soon retreated into his usual I’m-not-very-good mind-set. He is talking to the counselor about his misgivings about getting a job.

**ANAN:** I’ve had a few part-time jobs that didn’t amount to much. The business world is looking for people with experience. I don’t have any. So I think I just need a job, any job.

**COUNSELOR A:** Anan, why do you keep underselling yourself. You keep referring to yourself as, well, almost damaged goods. No one’s going to hire you if you keep doing that.

This counselor emphasizes the problem and browbeats the client. The following counselor takes a different tack.

**COUNSELOR B:** You’re right, experience is important. . . . But let’s step back a moment. In a very real sense you’ve had two different jobs for the last four years. One, being a student, a learner. Two, developing your ability to meet and get along with all sorts of people, being a good relater. Let’s discuss your track record in these two “jobs.”

**ANAN (pauses):** Well, OK. But school isn’t the real world.

**COUNSELOR B:** I'm not sure what you mean. I don't think you're saying that school's a phony world. So. . . .

**ANAN:** No, it isn't. I've learned a lot! And I get along well with just about everyone.

**COUNSELOR B:** Let's pretend I'm a recruiter. And I say, "Tell me what kind of learner you are. And then tell me what you're like in building and maintaining interpersonal relationships. Start with either one." How would you respond?

**ANAN:** They're not going to ask questions like that! I'm not sure what I'd say.

**COUNSELOR B:** Well, just try.

**ANAN (hesitatingly):** Well. . . . I'm a good learner (pauses).

**COUNSELOR B:** Meaning?

**ANAN (still hesitatingly):** Well, I study hard. I love getting a grasp on the fundamental concepts of whatever I'm learning. Maybe that's why I hate tests. So many of my classmates study just for tests. And some of my teachers teach to the test. I don't like that at all. But I love going deeply into whatever I'm learning.

They go on to deal with Anan's successes in his two main "jobs" and how he can use these successes as a candidate for jobs. They discuss the culture from which Anan comes, one that emphasizes being modest, one where unemployment was very high, and one in which even so-called "lowly" jobs were prized. Anan is a U.S. citizen now. COUNSELOR B helps him explore the consequences of excessive modesty and Anan's need to develop a self-presentation approach in which he neither oversells nor undersells himself: "In job interviews do you present yourself as a beggar or as an asset? Just tell the truth. If you belittle yourself, you are fudging. My bet is that you hate fudging."

The principles outlined above are, of course, guidelines, not absolute prescriptions. In the long run, use your common sense. Put yourself in the client's shoes. Get the client to tell what he or she needs from you. The more flexible you are, the more likely you are to add value to your clients' search for solutions. Box 7.1 summarizes ways of making your invitations to self-challenge both wise and robust.

## Avoid Shadow-Side Blocks to Challenge **LO 7.5**

There is an interesting body of literature on the humanity and flaws of helpers (Kottler, 2010) that can be of enormous help to both beginners—because prevention is infinitely better than cure—and to old-timers—because you can teach old dogs new tricks. Kottler has provided trainees and novices an upbeat view of what passion and commitment in the helping professions should look like.

Kim, Hollon, and Olatunji (2016) review some of the errors made by helpers who adopt a cognitive-behavior-emotion approach to therapy such as the one outlined in this book. These errors include a lack of a systemic approach to helping (this book does provide a system), lack of a collaborative approach to helping

(this book highlights helper-client collaboration), failure to adequately deal with clients' feelings (feelings receive equal treatment here), and a tacit assumption that a solid alliance will take care of everything (in these pages, the alliance, though important, is only one factor among many). They suggest that an over-emphasis on the alliance keeps counselors from holding clients accountable. This chapter suggests that helpers should not hold clients accountable. Rather they should invite clients to hold *themselves* accountable.

One of the critical responsibilities of supervisors is to help counselors identify their blind spots and learn from them. Once out of training, skilled helpers use different forums or methodologies to continue this process, especially with difficult cases. They take counsel with themselves, asking, "What am I missing here?" They take counsel with colleagues. Without becoming self-obsessed, they scrutinize and challenge themselves and the role they play in the helping relationship. Or, more simply, throughout their careers they continue to learn about themselves, their clients, and their profession. One way to identify and do something about your own blind spots as a helper is to elicit clear, honest feedback from your clients.

### **Avoid the "MUM Effect"**

Initially, some counselor trainees are quite reluctant to help clients challenge themselves. They become victims of what has been called the "MUM effect," the tendency to "keep mum about undesirable messages," to withhold bad news even when it is in the other's interest to hear it (Rosen & Tesser, 1970, 1971; Tesser & Rosen, 1972; Tesser, Rosen, & Bachelor, 1972; Tesser, Rosen, & Tesser, 1971). In ancient times, the person who bore bad news to the king was sometimes killed. That obviously led to a certain reluctance on the part of messengers to bring such news. Bad news—and, by extension, the kind of "bad news" involved in invitations to self-challenge—often arouses negative feelings in the challenger, no matter how he or she thinks the receiver will react. If you are comfortable with the supportive dimensions of the helping process but uncomfortable with helping as a social-influence process, you could fall victim to the MUM effect and become less effective than you might otherwise be.

### **Recognize Helper Excuses for Not Inviting Clients to Challenge Themselves**

Reluctance to challenge is not a bad starting position. In my estimation, it is a far better approach than being too eager to challenge. However, all helping, even the most client-centered, involves social influence. It is important for you to understand your reluctance (or eagerness) to challenge—that is, to challenge yourself on the issue of challenging and on the very notion of helping as a social-influence process. When trainees examine how they feel about inviting others to challenge themselves, here are some of the unexplored assumptions they discover.

- I am just not used to challenging others. My interpersonal style has had a lot of the live-and-let-live in it. I have misgivings about intruding into other people's lives.

- If I challenge others, then I open myself to being challenged. I may be hurt, or I may find out things about myself that I would rather not know.
- I might find out that I like challenging others, and the floodgates will open and my negative feelings about others will flow out. I have some fears that deep down I am an angry person.
- I am afraid that I will hurt others, damage them in some way or other. I have seen others hurt by heavy-handed confrontations.
- I am afraid that I will delve too deeply into others and find that they have problems that I cannot help them handle. The helping process will get out of hand.
- If I challenge others, they will no longer like me. I want my clients to like me.

Vestiges of this kind of thinking can persist long after trainees move out into the field as helpers. People in all sorts of people-oriented occupations, including human-service workers and managers, are bedeviled by the MUM effect and come up with their own set of excuses for not giving feedback. Of course, being willing to invite others to challenge themselves responsibly is one thing; having the skills and wisdom to do so is another. summarizes, in question form, how effective you are at making invitations to self-challenge a key part of your approach to helping.

# The Stages and Tasks of the Problem-Management and Opportunity-Development Model

One of the best ways of moving through Part III is to start by rereading Chapter 2, an overview of the problem-management and opportunity-development model or framework. There are four chapters in this section:

## The Chapters

- Chapter 8 deals with helping clients understand the importance of engaging in life-enhancing actions throughout the helping process whether it is short or long. Life-enhancing client outcomes are at the heart of therapy. But without client action there are no outcomes. The term action here is used in a broad sense. It consists in both internal and external behavior. For instance, eating nutritiously or providing for the financial needs of your family are external actions. Other people can see what you are doing. This is external behavior. It is in some sense public, capable of being seen by others whether it is actually seen or not. Controlling sexual daydreaming that tends to lead to what you see as inappropriate sexual behavior is an internal behavior. Assuring yourself that you have the talent and guts to finish a difficult work project is an internal action that fosters self-efficacy. Controlling your instinct to lash out at your partner when

you believe that he or she is trying to hurt you is an action relating to the emotional dimensions of life. In sum, behavior can be external, cognitive, or affective.

- Chapter 9 deals with the first stage of the helping process, a review of the client's problems, issues, concerns, and/or unused opportunities. There are three inter-related tasks answering three questions. What is the problem, that is, the presenting problem? What is the real problem, that is, the actual problem devoid of blind spots? What is the right problem, that is, one which, if managed well, will lead to desired life-enhancing outcomes?
- Chapter 10, Stage II of the helping process, deals with helping clients explore a better future in terms of life-enhancing outcomes. What are the possibilities for a better future? Which outcomes, when achieved, would handle the presenting problem situation and/or the unused opportunity? This chapter also focuses on helping clients find the motivation to do the hard work needed to get the work done?
- Chapter 11, Stage III of the helping process, deals with the kind of planning needed to move into action and accomplish the problem-managing goals chosen in Stage II. "Now that I know where I want to go, how do I get there?"

## The CAVEAT, Once More

This message is so important that it needs to be repeated and repeated. The logic seen in this book in terms of communication skills and a helping process that has stages and tasks within each stage is just that—logic. It is the geography of helping, but it is not the story played out in that geography. It is the map, but it is not the journey. Helping clients deal successfully with their issues and concerns is the heart of helping. If you learn the model and the skills that make it work, you will be smart. If you learn how to use it flexibly at the service of your clients, you will be wise. If you can help clients move around wherever they need to in order to manage their lives better, you will be even wiser. In the end, it is not what you do. It is what clients do to make their lives better. Start wherever the client needs to start. Move wherever the client needs to go. Go back and forth. Make mistakes and recover from them. Let clients make mistakes and then help them learn from them. Be an entrepreneur whose principal focus is the client's success.



# The Action Arrow: Right from the Beginning Help Clients Turn Talk into Life-Enhancing Action

## LEARNING OBJECTIVES

### 8.1 Understand the Importance of the Action Arrow

### 8.2 Find Ways of Helping Clients Move to Life-Enhancing Action

Help Clients Discover the Value of Action Intentions

Help Clients Overcome Procrastination

Help Clients Identify Unused Resources That Can Facilitate Action.

Help Clients Find Incentives and Rewards for Action

Help Clients Develop Action-Focused Self-Contracts

Help Clients Find and Utilize Action-Focused Social Support

Help Clients Find People Willing to Challenge Them to Act

Use Feedback as a Way of Helping Clients Move to Life-Enhancing Action

Help Clients Use Checklists as a Way of Initiating Directional Action

Help Clients Identify Possible Obstacles to Action

Help Clients Deal with Inertia

Help Clients Deal with Entropy: The Tendency of Things to Fall Apart

Help Clients Avoid Imprudent Action

### 8.3 Understand How Reluctance and Resistance Are Obstacles to Action

See Reluctance as Misgivings about Change

See Resistance as Reacting to Coercion

### 8.4 Use Guidelines for Helping Clients Deal with Reluctance and Resistance

Avoid Unhelpful Responses to Reluctance and Resistance

Develop Productive Approaches to Dealing with Reluctance and Resistance

Avoid Helper Reluctance and Resistance

### 8.5 Help Clients Tap into Their Resilience, the Ability to Bounce Back and Grow

Help Clients Discover Their Resilience

Encourage Both Bounce-Back Action and Steady-State Action

Understand Factors Contributing to Resilience

Note the Relationship of Resilience to Posttraumatic Growth

### 8.6 Help Clients Get Along without a Helper

### 8.7 Remember that Some Clients Choose Not to Change

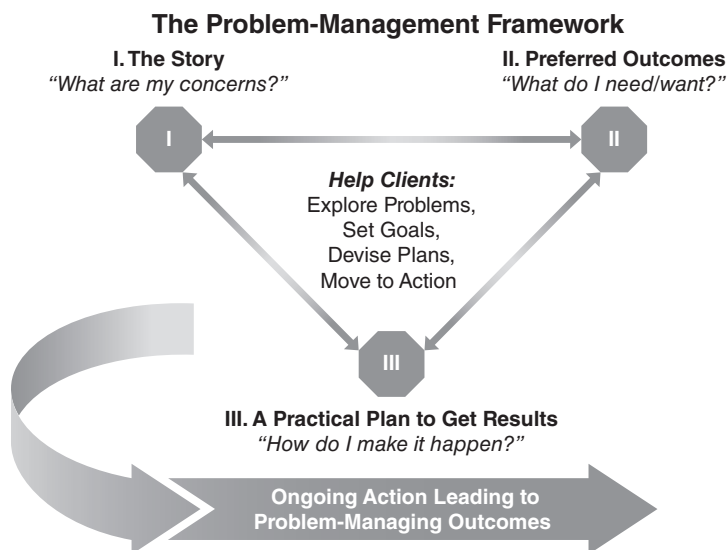
## Understand the Importance of the Action Arrow LO 8.1

It may seem odd to talk about action before discussing the problem-managing goals and the plans needed to accomplish these goals. However, Figure 8.1 shows that action needs to characterize every stage and task of the helping process. The value called “a bias toward action” discussed in Chapter 3 needs to be alive at every stage and in every task of the change process. The **action arrow** highlights the difference between talking about problems and doing something about them. Stages I, II, III, and their nine tasks (see Chapter 2) deal with the logic of change, not change itself. Indeed, talking about change but failing to act to make the desired change happen is a central problem in all areas of human life—business, religion, politics, community development, education, and day-to-day living. For instance, in my (GE) view, although educational theory and research have led to brilliant innovations on paper, only a fraction of these innovations find their way into classrooms. Some business consultants estimate that over 80% of change programs in the business world never see the light of day. “What happened to the management development program we started last year?” Therefore the need to incorporate action into planning and planning into action is at the heart of change. Client action is at the heart of counseling and therapy. This chapter takes a detailed look at helping clients engage in results-producing action. It influences everything in Chapters 9, 10, and 11.

Some clients, once they have a clear idea of what to do to handle a problem situation or develop some opportunity, go ahead and do it, whether or not they have a formal plan. They need little or no further support and challenge from their helpers. They either find the resources they need within themselves or get support and challenge from the significant others in the social settings of their lives. However, other clients choose goals and come up with strategies for implementing them, but are, for whatever reason, stymied when it comes to action. Most clients fall between these two extremes.

Self-determination and self-control are essential for action. Kanfer and Schefft (1988, p. 58) differentiated between two kinds of self-control. In *decisional* self-control, a single choice terminates a conflict. For instance, a woman decides to leave an abusive spouse and goes through with it. In *protracted* self-control, continued resistance to temptation is required. For instance, it is not enough for a client with severe health problems to begin a demanding nutritional, exercise, and stress-reduction program. She also has to remain vigilant and committed day in and day out. Each time a temptation to backslide arises she has to renew her resolve. It helps enormously if she develops the attitude that temptations are learning opportunities and not just battles to be fought. She needs to find ways to make the struggle itself tolerable or even rewarding. One client would eat a carrot when she was tempted to give into nutritional temptation. As she munched, she said to herself, “I’m not enjoying this as much as a rabbit would, but it’s not bad.”

Most clients need both kinds of self-control to manage their lives better. A client’s choice to give up alcohol completely (decisional self-control) needs to be complemented by the ability to handle inevitable longer-term temptations. Protracted self-control calls for a preventive mentality and a certain degree of

**FIGURE 8.1**

The Action Arrow and Change

street smarts. It is easier for the client who has given up alcohol to turn down an invitation to go to a bar in the first place than to sit in a bar all evening with friends and refrain from drinking.

When it comes to client action, Norcross, Krebs, and Prochaska (2011) urge caution: “Beware treating all patients as though they are in action” (p. 294) because most arrive not ready for action. This causes a dilemma because the sooner clients begin to act on their own behalf the more likely are they to succeed. Your job is to help clients bridge this gap. But, as Johancsen-Walt (2010) notes, progress in therapy is often an “accumulation of small changes, plateaus, and regressions” (p. 50) and patience on the part of both client and helper is essential.

Plans for accomplishing goals need to be complemented by tactics and logistics. A *strategy* is a practical plan or program to accomplish some objective. *Tactics* is the art of adapting a plan to the immediate situation. This includes being able to change the plan on the spot to handle unforeseen complications. *Logistics* is the art of being able to provide the resources needed for the implementation of a plan in a timely way. Here is a simple case illustrating all three.

During the summer, Rebecca wanted to take an evening course in statistics so that the first semester of the following school year would be lighter. Having more time would enable her to act in one of the school plays, a high priority for her. But she didn’t have the money to pay for the course, and at the university she planned to attend prepayment for summer courses was the rule. Rebecca had counted on paying for the course from her summer earnings, but she would not have the money until later. Consequently, she did some quick shopping around and found that the same course was being offered by a community college not too far from where she lived. Her tuition there was minimal, because she was a resident of the area the college served.

**BOX 8.1****Questions on the Importance of Client Action**

Here are the kinds of questions you can help clients ask themselves as they explore the importance of action in creating a better life for themselves.

- Once I have developed a plan, how do I move into action?
- What kind of self-starter am I? How can I improve?
- What obstacles lie in my way? Which are critical?
- How can I manage these obstacles?
- How do I keep my efforts from flagging?
- What do I do when I feel like giving up?
- What kind of support will help me to keep going?
- What role does hope play in my search for a better life?
- What's my track record with life-enhancing change?

In this example, Rebecca keeps to her overall plan (strategy). However, in light of an unforeseen circumstance, the demand for prepayment, she adapts her immediate plan (a tactic) by locating another resource (logistics). Because many well-meaning and motivated clients are simply not good tacticians and are not good at finding the resources they need, counselors can add value by using the following principles to help them engage in focused and sustained goal-accomplishing action. Box 8.1 is a set of questions you can ask yourself about your own bias toward action. You may well find answers to these questions in what follows.

## **Find Ways of Helping Clients Move to Life-Enhancing Action**

**LO 8.2**

There are many ways to help clients not only move to action but also, more generally, to develop the bias toward action described in Chapter 3. Two kinds of client action are important. First, the behaviors related to the client's participation in the helping process itself. To what degree is the client an active participant? Second, the behaviors related to problem-management and opportunity-development outcomes. To what degree does the client pursue life-enhancing outcomes in his or her daily life? Obviously both are important. But in some ways it is possible for a client to be a "good participant," say, in exploring problem situations and setting goals without doing whatever is necessary to pursue and accomplish these goals. What follows is a number of ways you can help clients pursue and achieve life-enhancing outcomes.

### **Help Clients Discover the Value of Action Intentions**

In the research literature these are called "implementation" intentions because they are often associated with implementing plans to achieve goals. Mere commitment to goals and plans to achieve them is not enough. Commitment must

be accompanied or followed by commitment to the courses of action needed to accomplish these goals. Gollwitzer and associates (Achtziger, Gollwitzer, & Sheeran, 2008; Bayer & Gollwitzer, 2007; Gollwitzer, 1999; Gollwitzer & Sheeran, 2006; Oettingen & Gollwitzer, 2010; Webb & Sheeran, 2006) have researched a simple way to help clients cope with the common problems associated with translating goals into action—failing to get started, becoming distracted, reverting to bad habits, and so forth. Even strong commitment to goals is not enough. Equally strong commitment to specific actions to accomplish goals is required. Good intentions, Gollwitzer and associates point out, do not deserve their poor reputation.

Strong intentions—“I strongly intend to study for an hour every weekday before dinner”—are “reliably observed to be realized more often than weak intentions” (p. 493). . . . **Implementation intentions** are subordinate to goal intentions and specify the when, where, and how of responses leading to goal attainment. They have the structure of “When situation x arises, I will perform response y!” and thus link anticipated opportunities with goal-directed responses. (p. 494)

Consider the case of Gwendolyn, an aide in a nursing home who is reviewing the way she attends to the needs of difficult or abusive patients.

Gwendolyn says to herself, “When Enid [a patient] becomes abusive, I will not respond immediately. I’ll tell myself that it’s her illness that’s talking. Then I’ll respond with patience and kindness.” Her ongoing goal is to control her anger and other negative responses to patients. However, Gwendolyn keeps pursuing this goal by continually refreshing her strong implementation intentions. Because Enid has been a particularly difficult patient, Gwendolyn needs to refresh her intentions frequently. However, her initial strong intention to substitute anger and impatience with kindness and equanimity means that in most cases her responses are more or less automatic. The environmental cue—patient anger, abuse, lack of consideration, and whatever—triggers the appropriate response in Gwendolyn. In a way, poor patient behavior provides cues or opportunities for her responses.

You can help clients enunciate to themselves strong specific intentions that will help them almost automatically move into goal-accomplishing action. For instance, the person trying to manage his or her weight gets the menu in the restaurant and automatically looks for the right kind and amount of food. “I’ll have the vegetarian entrée, thank you.” The research being done on implementation intentions has great pragmatic value with respect to translating goals into accomplishments.

Commitment intentions can take place anywhere in the helping process, even right at the beginning. Toward the end of the first counseling session that was going nowhere, one client—in response to my (GE) saying, “I’m not sure where we’re going here so I’m not sure what I can do to help”—paused and then said, “It’s not you, it’s me. I’m not prepared for what we’re doing. I’d like to think about what I need to talk about, what I fear, what I’m afraid to learn about myself. Then I’d like to come back next week and start over. I want to be ready. Is that OK?” And he did return ready to work.

## Help Clients Overcome Procrastination

At the other end of the spectrum are clients who keep putting action off. The gap between knowing and doing (Kegan & Lahey, 2010; Pfeffer & Sutton, 2000)

has been with us from time immemorial and will probably remain with us till the earth disappears. “Competing agendas” can stand in the way of change. We have too many things to do and tend to do the things we want to do instead of the things we should do. This is a form of procrastination. Kegan and Lahey take this concept further. They talk about how clients’ “hidden commitments” stand in the way of change. For instance, a principal thinks that she should get out of her office and into classrooms more often, but she never finds the time. What hidden commitments might keep her from changing her behavior? Well, she might be afraid of what she will find in any given classroom. But what hidden commitment stands in the way? The school has a “comfortable” faculty culture that she might disrupt. Or she might be afraid of going into math and science classroom because math and science are not her forte. She may be shown up. What’s her hidden commitment? Authority figures should stay on the pedestal. This is important for order in the institution. We all have hidden commitments that keep us from changing. So do our clients. We need to challenge ours and help clients become aware of and challenge theirs.

There are many other reasons for procrastination (Ferrari, 2010; Ferrari, Johnson, & McCowan, 1995; Pychyl, 2010). Each person has his or her set of factors that create what Kegan and Lahey call their personal “immunity to change.” Many clients procrastinate because they focus on the short-term pain of moving into action even when they can clearly see the long-term benefits of doing so. Take the case of Eula.

Eula, disappointed with her relationship with her father in the family business, decided that she wanted to start her own. She thought that she could capitalize on the business skills she had picked up in school and in the family business. Her goal, then, was to establish a small software firm that created products for the family-business market. But a year went by and she still did not have any products ready for market. A counselor helped her see two things. First, her activities—researching the field, learning more about family dynamics, going to information technology seminars, getting involved for short periods with professionals such as accountants and lawyers who did a great deal of business with family-owned firms, drawing up and redrafting business plans, and creating a brochure—were helpful, but they did not produce products. The counselor helped Eula see that at some level of her being she was afraid of starting a new business. She had a lot of half-finished products. Over preparation and half-finished products were signs of that fear. So she plowed ahead, finished a product, and brought it to market on the Internet. To her surprise, it was successful. Not a roaring success, but it meant that the cork was out of the bottle. Once she got one product to market, she had little problem developing and marketing others.

Eula certainly was not lazy. She was very active. She did all sorts of useful things. But she let herself become a victim of what Andreou (2007) calls “second-order” procrastination. Second-order procrastination is procrastinating on implementing a solution to procrastination itself. Eula avoided getting around to accomplishing the most critical actions—creating and marketing products.

The opposite of procrastination is a sense of urgency that leads to timely problem-managing action. Kotter (2008) suggests that change, and this applies to personal change, does not start, continue, or “stick” without a sense of urgency.

But he distinguishes between true and false urgency. The former means doing the right things in a timely way. False urgency refers to activity, even intense activity, which goes nowhere. It looks like urgency but isn't the real thing.

Partnoy (2012) suggests that not all forms of procrastination are bad. Delaying decisions and actions gives clients time to think more carefully about possible unintended consequences of acting, especially the consequences of acting too quickly. So Partnoy suggests that there is good procrastination and bad—but perhaps this is something that most of us already know.

### **Help Clients Identify Unused Resources That Can Facilitate Action**

We need to find ways of helping clients substitute “I can’t” with “I can” and “I can” with “I will.” One way is help them identify unused resources that facilitate action.

Nora found it extremely depressing to go to her weekly dialysis sessions. She knew that without them she would die, but she wondered whether it was worth living if she had to depend on a machine. The counselor helped her see that she was making life more difficult for herself by letting herself think such discouraging thoughts. He helped her learn how to think thoughts that would broaden her vision of the world instead of narrowing it down to herself, her discomfort, and the machine. Nora was a religious person and found in the Bible a rich source of positive thinking. She initiated a new routine: The day before she visited the clinic, she began to prepare herself psychologically by reading from the Bible. Then, as she traveled to the clinic and underwent treatment, she meditated slowly on what she had read.

In this case, the client substituted positive thinking, an underused resource, for poor-me thinking. Brainstorming resources that can counter obstacles to action can be very helpful for some clients. Helping clients brainstorm facilitating forces raises the probability that they will act in their own interests.

In our view one of the most underused action-focused resources in counseling is insight. When a client says something like “For the first time I really understand how counterproductive my sarcastic humor is,” we fail him or her if we do not help him change his style. Insights that remain just that, insights, are lost opportunities. Or consider this case:

A manager I (GE) was coaching came to me after attending a lecture I gave on leadership. He said, “It hit me like a ton of bricks when you said that one of the main reasons discussions of leadership are so muddled is the failure to distinguish between headship and leadership. Headship is positional. Leadership is about results beyond the ordinary. Many heads are not leaders at all.” He went on to say, “I realized in an instant that I have been trying to use organizational politics to climb the ladder, to get better and better positions. How cheap! How phony! Leadership is about company-enhancing innovation. Boy, do I have to change my approach. I’m good at innovation but I haven’t done much about it.” We went on to discuss much more concretely what he was going to do. He concluded, “If I exercise leadership, then the positions will come.”

In this case the helper provided the insight but the client turned the insight into an action. One of the best things you can do is to help clients turn useful insights into action.



## Help Clients Find Incentives and Rewards for Action

Clients avoid engaging in action programs when the incentives and the rewards for *not* engaging in the program outweigh the incentives and the rewards for doing so (Pink, 2009). The counselor in this case thinks that he is justified in taking a tough confrontational approach to helping.

Miguel, a police officer on trial for use of excessive force with a young offender, had a number of sessions with a counselor from an HMO that handled police health insurance. During the sessions, the counselor learned that although this was the first time Miguel had run afoul of the law, it was in no way the first expression of a brutal streak within him. He was a bully on the beat and a despot at home, and had run-ins with strangers when he visited bars with his friends. During the trial, witnesses recalled instances of these behaviors.

Up to the time of his arrest, he had gotten away with all of this, even though his friends had often warned him to be more cautious. His badge had become a license to do whatever he wanted. His arrest and now the trial shocked him. Before, he had seen himself as invulnerable; now, he felt very vulnerable. The thought of being an ex-cop in prison understandably horrified him. He was found guilty, was suspended from the force for several months, and received probation on the condition that he continues to see the counselor.

Beginning with his arrest, Miguel had modified his aggressive behavior a great deal, even at home. Of course, fear of the consequences of his aggressive behavior was a strong incentive to change. The next time, the courts would show no sympathy. The counselor took a tough approach to this tough cop. He confronted Miguel for “remaining an adolescent” and for “hiding behind his badge.” He called the power Miguel exercised over others “cheap power.” He challenged the “decent person” to “come out from behind the screen.” He told Miguel point-blank that the fear he was experiencing was probably not enough to keep him out of trouble in the future. After probation, the fear would fade and Miguel could easily fall back into his old ways. Even worse, fear was a “weak man’s” crutch.

On a more positive note, the counselor saw in Miguel’s expressions of vulnerability the possibility of a much more decent human being, one “hiding” under the tough exterior. The real incentives, he suggested, came from the “decent guy” buried inside. He had Miguel paint a picture of a “tough but decent” cop, family man, and friend. He had Miguel come up with “experiments in decency”—at home, on the beat, with his buddies—to get first-hand experience of the rewards associated with decency.

The counselor was not trying to change Miguel’s personality. Indeed, he did not believe in personality transformations. But he pushed him hard to find and bring to the surface a different, more constructive set of incentives to guide his dealings with people. The new incentives had to drive out the old. This counselor’s approach seems to run up against a lot that has been said about responsible helping. What is your view? If you were Miguel’s counselor, what approach would you take?

The incentives and rewards that help a client get going on a program of constructive change in the first place may not be the ones that keep the client going.

Dwight, a man in his early 30s who was recovering from an accident at work that had left him partially paralyzed, had begun an arduous physical rehabilitation program with great commitment. Now, months later, he was ready to give up.

The counselor asked him to visit the children's ward. Dwight was both shaken by the experience and amazed at the courage of many of the kids. He was especially struck by one teenager who was undergoing chemotherapy. "He seems so positive about everything," Dwight said. The counselor told him that the boy was tempted to give up, too. Dwight and the boy saw each other frequently. Dwight put up with the pain. The boy hung in there. Three months later, the boy died. Dwight's response, besides grief, was, "I can't give up now; that would really be letting him down. I've got to keep my part of the bargain."

Dwight's partnership with the teenager proved to be an excellent incentive. It helped him renew his resolve. Although the counselor joined with Dwight in celebrating his newfound commitment, he also worked with Dwight to find "backup" incentives for those times when current incentives seem to lose their power.

Constructive-change activities that are not rewarded tend over time to lose their vigor, decrease, and even disappear. This process is called extinction. It was happening with Luigi.

Luigi, a middle-aged man, had been in and out of mental hospitals a number of times. He discovered that one of the best ways of staying out was to use some of his excess energy helping others. He had not returned to the hospital once during the three years he worked at a soup kitchen. However, finding himself becoming more and more manic over the past six months and fearing that he would be sent back to the hospital, he sought the help of a counselor.

Luigi's discussions with the counselor led to some interesting findings. He discovered that, whereas in the beginning he had worked at the soup kitchen because he wanted to, he was now working there because he thought he should. He felt guilty about leaving and also thought that doing so would lead to a relapse. In sum, he had not lost his interest in helping others, but his current work was no longer interesting or challenging. As a result of his sessions with the counselor, Luigi began to work for a group that provided housing for the homeless and the elderly. He poured his energy into his new work and his manic episodes subsided.

The lesson here is that incentives cannot be put in place and then be taken for granted. They need tending.

## Help Clients Develop Action-Focused Self-Contracts

Self-contracts—that is, contracts that clients make with themselves—can also help clients commit themselves to new courses of action. Although contracts are promises clients make to themselves to behave in certain ways and to attain certain goals, they are also ways of making goals more focused. It is not only the expressed or implied promise that helps but also the explicitness of the commitment. Consider the following example, in which one of Dora's sons disappears without a trace.

About a month after one of Dora's two young sons disappeared, she began to grow listless and depressed. She was separated from her husband at the time the boy disappeared. By the time she saw a counselor a few months later, a pattern of depressed behavior was quite pronounced. Although her conversations with the counselor helped ease her feelings of guilt—for instance, she stopped engaging in self-blaming rituals—she remained listless. She shunned relatives and friends, kept to herself at

work, and even distanced herself emotionally from her other son. She resisted developing images of a better future, because the only better future she would allow herself to imagine was one in which her son had returned.

Some strong challenging from Dora's sister-in-law, who visited her from time to time, helped jar her loose from her preoccupation with her own misery. "You're trying to solve one hurt, the loss of Bobby, by hurting Timmy and hurting yourself. I can't imagine in a thousand years that this is what Bobby would want!" her sister-in-law screamed at her one night. Afterward, Dora and the counselor discussed a "recommitment" to Timmy, to herself, to the extended family, and to their home. Through a series of contracts, she began to reintroduce patterns of behavior that had been characteristic of her before the tragedy. For instance, she contracted to opening her life up to relatives and friends once more, creating a much more positive atmosphere at home, encouraging Timmy to have his friends over, and so forth. Contracts worked for Dora because, as she said to the counselor, "I'm a person of my word."

When Dora first began implementing these goals, she felt she was just going through the motions. However, what she was really doing was acting herself into a new mode of thinking. Contracts helped Dora in both her initial commitment to a goal and her movement to action. In counseling, contracts are not legal documents but human instruments to be used if they are helpful. They often provide both the structure and the incentives some clients need.

Even self-contracts have a shadow side. There is no such thing as a perfect contract. Most people don't think through the consequences of all the provisions of a contract, whether it is marriage, employment, or self-contracts designed to enhance a client's commitment to goals. And even people of goodwill unknowingly add covert codicils to contracts they make with themselves and others—"I'll pursue this goal—until it begins to hurt" or "I won't be abusive—unless she pushes me to the wall." The codicils are buried deep in the decision-making process and only gradually make their way to the surface.

Earlier we discussed self-contracts as a way of helping clients commit themselves to what they want—that is, their goals. Self-contracts are also useful in helping them both initiate and sustain problem-managing action and the work involved in developing opportunities. Self-contracts and agreements with others focus clients' energies. Sherman and her associates (2008) point out the obstacles to getting family, spouses, partners, and friends to provide support for veterans with PTSD. Family members shy away for a number of reasons: no one has enlisted their help, they live too far away, they have unchallenged beliefs such as "what goes on behind closed doors is not to be discussed," they are reluctant to make an effort to understand the veteran, and they fear being exposed to upsetting information. Spouses and partners have misgivings about engaging in formal programs, feel hopeless about the veteran's ability to improve, become resigned to being lifelong caregivers, and feel that most of their attention should be given to their children. Perhaps the main problem with social support is that it does not happen automatically. Involved parties—client, helper, and others—have to make it happen. In some sense of the terms relevant parties need to be enrolled. Karlan (2008) demonstrates the power of commitment contracts. His website ([www.stickK.com](http://www.stickK.com)) allows people to set a goal, determine the stakes for not

pursuing the goal, choose a referee to determine if progress is being made, and get supporters' help in staying on target. Public commitment works. If you share your change agenda "with the world," it is easier to move forward and harder to give up. Transparency helps. The StickK system tends to work because it provides incentives that work with most people. The principles Karlan outlines—goal setting, putting stakes at risk, an objective referee, and transparency can, with some adaptation, be used in therapy.

In the following case, several parties had to commit themselves to the provisions of a commitment contract.

A boy in the seventh grade was causing a great deal of disturbance by his outbursts in class, which included verbal jousting with his friends and profanity. The apparent purpose of the disruptions was to position himself among his friends. He seemed to want to cultivate a reputation for being unafraid of the teachers and the principal. The punishments handed down by them were dwarfed by what he saw as the admiration of his friends. After the teacher discussed the situation with the school counselor, the counselor called a meeting of all the stakeholders—the boy, his parents, the teacher, and the principal. The counselor offered a simple contract. When the boy disrupted the class, he would spend the next day working by himself under the direction of a teacher's aide. This would take him away from his friends. The day after, he would return to the classroom. There would be no further punishment. Concurrently, the counselor would work with him on what "leadership" behavior in the classroom might look like.

The first month, the boy spent a fair number of days with the teacher's aide. The second month, however, he missed only 2 days, and the third month only 1. The truth is that he really wanted to be in school with his classmates. That's where the action was. And so he paid the price of self-control to get what he wanted. He also began to discover more constructive forms of leadership behavior. For instance, on occasion he challenged what the teacher was saying about a particular topic. Sometimes this led to a very lively classroom debate. Even the teacher thought that the boy's behavior was responsible and added value.

The counselor had suspected that the boy found socializing with his classmates rewarding. But now he had to pay for the privilege of socializing. Reasonable behavior in the classroom was not too high a price. This was more than just a self-contract. Other stakeholders were involved. Getting others involved increases the likelihood that progress toward the goal will be made. The more you know about the power of incentives, the more clients will benefit.

### **Help Clients Find and Utilize Action-Focused Social Support**

As we will see, planning includes helping clients identify the resources, both internal and environmental, they need to pursue goals. One of the most important resources is social support (Barker & Pistrang, 2002; Seeman, 1996; Taylor, 2007; Taylor and associates, 2004), though, surprisingly enough, research to verify the usefulness of social support is skimpy (Cruza-Guet and associates, 2008; Hogan, Linden, & Najarian, 2002; Roehrle & Strouse, 2008), highlighting once more the not infrequent necessity of common sense to outpace "science." Lakey (2010) contends that despite the need for an understanding of social support on the part of helpers, the helping professions "still lack sufficient understanding

of social support processes to create effective, new interventions” (p. 177). The starting point for understanding social support is the client and his or her relationship with the support provider. The kind and quality of the relationship has, perhaps, the most influence when it comes to social support (Lakey, 2010). So-called objectively supportive people or actions are actually so only if they are perceived to be so by the client. *How* people provide support is also critical in the eyes of the recipient. Sometimes “supportive” people, especially those with “good intentions,” wonder why they are being shunned by those they are trying to support. Yet most practitioners see social support as a key element in problem-managing change.

Social support has . . . been examined as a predictor of the course of mental illness. In about 75% of studies with clinically depressed patients, social-support factors increased the initial success of treatment and helped patients maintain their treatment gains. Similarly, studies of people with schizophrenia or alcoholism revealed that higher levels of social support are correlated with fewer relapses, less frequent hospitalizations, and success and maintenance of treatment gains. (Basic Behavioral Science Task Force of the National Advisory Mental Health Council, 1996, p. 628)

While helpers themselves can provide a great deal of support, still, if clients are to pursue goals “out there” in their real lives, their main support should also be out there. Unfortunately, such support may not always be easy to find (Putnam, 2000). In North American society, the supply of “social capital”—both informal social connectedness and formal civic engagement—has fallen. We belong to fewer organizations that conduct meetings, know our neighbors less, meet with friends less frequently, and even socialize with our families less often. Yet this is the environment in which clients must do the work of constructive change.

In a study on weight loss and maintaining the loss (Wing & Jeffery, 1999), clients who enlisted the help of friends were much more successful than clients who took the solo path. This is called “social facilitation” and is quite different from dependence. Social facilitation is energizing, whereas dependence is often limiting and depressing. Therefore a culture of social isolation does not bode well for clients. Of course, all of this reinforces what we already know through common sense. Who among us has not been helped through difficult times by family and friends?

When it comes to social support, there are two categories of clients. First, there are those who lead an impoverished social life. The objective with this group is to help them find social resources, to get back into community in some productive way. But what about clients who do have people they can turn to? Well, as Putnam points out, even when clients, at least on paper, have a social system, they may not use it very effectively. This provides counselors with a different challenge—that is, helping clients tap into those human resources in a way that helps them manage problem situations more effectively. Consider this example.

Casey, a bachelor whose job involved frequent travel literally around the world, fell ill. He had many friends, but they were spread around the world. Because he was neither married nor in a marriage-like relationship, he had no primary caregiver in his life. He received excellent medical care, but his psyche fared poorly. Once

out of the hospital, he recuperated slowly, mainly because he was not getting the social support he needed. In desperation, he had a few sessions with a counselor, sessions that proved to be quite helpful. The counselor challenged him to “ask for help” from his local friends. He had underplayed his illness with them because he didn’t want to be a “burden.” He discovered that his friends were more than ready to help. But because their time was limited, he, with some hesitancy, “grafted” onto his rather sparse hometown social network some very caring people from the local church. He was fearful that he would be deluged with piety, but instead he found people like himself. Moreover, they were, in the main, socially intelligent. They knew how much or how little care to give. In fact, most of the time their care was simply an exercise of friendship.

Casey was likeable. What about those who are less likeable? The National Advisory Mental Health Council study just mentioned showed that people who are highly distressed and therefore most in need of social support may be the least likely to receive it because their expressions of distress drive away potential supporters. Who among us has not avoided at one time or another a distressed friend or colleague? Therefore distressed clients can be helped to learn how to modulate their expressions of distress. Who wants to help whiners? On the other hand, potential supporters can learn how to deal with distressed friends and colleagues, even when these friends and colleagues let themselves become whiners.

### **Help Clients Find People Willing to Challenge Them to Act**

In Chapter 7 we discussed how counselors can invite clients to challenge themselves in constructive ways. But therapists can also help clients look for these “invitations” on their own in their day-to-day lives. Review Chapter 7 which deals with invitations to self-challenge. Support without challenge can be hollow just as challenge without support can be abrasive. Ideally, the people in the lives of clients can provide a judicious mixture of encouragement and challenge.

Harry, a man in his early 50s, was suddenly stricken with a disease that called for immediate and drastic surgery. He came through the operation quite well, even getting out of the hospital in record time. For the first few weeks he seemed, within reason, to be his old self. However, he had problems with the drugs he had to take following the operation. He became quite sick and took on many of the mannerisms of a chronic invalid. Even after the right mix of drugs was found, he persisted in invalid-like behavior. Whereas right after the operation he had “walked tall,” he now began to shuffle. He also talked constantly about his symptoms and generally used his “state” to excuse himself from normal activities.

At first Harry’s friends were in a quandary. They realized the seriousness of the operation and tried to put themselves in his place. They provided all sorts of support. But gradually they realized that he was adopting a style that would alienate others and keep him out of the mainstream of life. Support and encouragement were essential, but not enough. They used a variety of ways (some included a bit of dark humor) to invite Harry to challenge himself to stay on the road to recovery. They mocked his “invalid” movements, engaged in serious one-to-one talks, turned a deaf ear to his discussion of symptoms, and routinely including him in their plans. Harry did not always react graciously to his friends’ challenges, but in his better moments he admitted that he was fortunate to have such friends. He died three years later, but because of the challenges of his friends, he lived quite a full life until the end.



Counselors can support clients in their search for people willing to provide a judicious mixture of encouragement and challenge.

### **Use Feedback as a Way of Helping Clients Move to Life-Enhancing Action**

Feedback was identified in Chapter 1 as one of the key ingredients of successful therapy (Lambert, 2010a). Feedback on progress toward problem-managing outcomes at the beginning of each therapy session and on the quality and value of the interactions during therapy at the end of each session is a principal contributor to client action throughout the helping process. If therapy is ultimately defined by life-enhancing outcomes, then two-way feedback within the session is crucial. Feedback helps both client and therapist engage in course correction. Dorner's (1998) research found that successful project managers reviewed their progress, looked for unanticipated and unintended consequences, and corrected course often. The same could be said of clients and their helpers.

Feedback from significant others in clients' everyday lives also goes far in helping them start acting on their own behalf and persevere even when the going gets rough. Gilbert (1978, p. 175), in his book on human competence, claimed that "improved information has more potential than anything else I can think of for creating more competence in the day-to-day management of performance." Feedback is certainly one way of providing both encouragement and challenge. If clients are to be successful in implementing their action plans, they need adequate information about how well they are performing. If goals and the path to these goals are clear, clients will know whether they are making progress or not. But sometimes clients need a more objective view of their progress. The purpose of feedback is not to pass judgment on clients' performance but rather to provide information, guidance, support, and challenge to help them move forward. There are two kinds of feedback.

**Confirmatory feedback** Through confirmatory feedback, significant others—such as helpers, relatives, friends, and colleagues—let clients know that they are on course; that is, moving successfully through the steps of an action program toward a goal.

**Corrective feedback** Through corrective feedback, significant others let clients know that they have wandered off course and specify what they need to do to get back on.

Corrective feedback, whether from helpers or people in the client's everyday life, should incorporate the following principles:

- Help clients to give feedback to themselves.
- Give feedback in the spirit of caring.
- Remember that mistakes are opportunities for growth.
- Use a mix of both confirmatory and corrective feedback.
- Be concrete, specific, brief, and to the point.
- Focus on the client's behaviors rather than on more elusive personality characteristics.
- Help clients see whether their behavior is helping or hindering their movement toward problem management of opportunity development.
- Help clients explore the impact and implications of the behavior.



- Avoid negative language arising from impatience (“Gee, that was a stupid thing to do!”).
- Provide feedback in moderate doses. Overwhelming the client defeats the purpose of the entire exercise.
- Engage the client in dialogue. Invite the client not only to comment on the feedback but also to expand on it. Lectures do not usually help.
- Help the client discover alternative ways of doing things. If necessary, make suggestions.
- Help clients explore the upside of changing and the downside of not changing.

The spirit of these “rules” should also govern confirmatory feedback. Very often people give very detailed corrective feedback and then just say “nice job” when a person does something well. All feedback provides an opportunity for learning. Consider the following statement from a father talking to his son, who stood up for the rights of a friend who was being bullied by some of his high school classmates:

Paul, I’m proud of you. You stood your ground even when they turned on you. They were mean. You weren’t. You gave your opinion calmly, but forcefully. You didn’t apologize for what you were saying. You were ready to take the consequences. It’s easier now that a couple of them have apologized to you, but at the time you didn’t know they would. You were honest to yourself. And now the best of them appreciate it. It made me think of myself. I’m not sure that I would have stood my ground the way you did (he pauses), but I’m more likely to do so now.

Although not as brief, this is much more powerful than “I’m proud of you, son.” Being specific about behavior together with pointing out the impact of the behavior turns positive feedback into an action-focused learning experience. Of course, one of the main problems with feedback is finding people in the client’s day-to-day life who see the client in action enough to make it meaningful, who care enough to give it, and who have the skills to provide it constructively.

### **Help Clients Use Checklists as a Way of Initiating Directional Action**

A lot of jokes have been made about people who let checklists, often ignored, rule their lives. One obsessive artist even made a list of his lists. Gawande (2010) showed how the use of the checklist reduced the number of medical errors in hospitals and saved thousands of lives. In his book he tries to show the value of checklists in many other areas of life. Though he has his critics (Howard, 2010) and the overuse of checklists can be stultifying, they can be very useful in therapy. To-do lists can help clients move into action, stay the course, and even change the course when necessary. Howard rightly cautions that checklists can stand in the way of creativity: “If [clients] are thinking about a checklist, they may not be focused on solving the problem” (p. A21). What he is really saying, however, is that the misuse or overuse of any methodology is often self-defeating. In therapy, a to-do list reminds clients of the importance of action and progress. Clients who stay in the driver’s seat use to-do lists rather than becoming captives of them.

### **Help Clients Identify Possible Obstacles to Action**

Years ago Kurt Lewin (1969) codified common sense by developing what he called “force-field analysis.” In ordinary language, this is simply a review by the

client of the major obstacles to and the major facilitating forces for implementing action plans. The slogan is “forewarned is forearmed.”

The identification of possible obstacles or restraining forces to the implementation of a program helps forewarn clients.

Raul and Maria, a childless couple living in a large Midwestern city, had been married for about five years and had not been able to have children. They finally decided that they would like to adopt a child, so they consulted a counselor familiar with adoptions. The counselor helped them work out a plan of action that included helping them examine their motivation, reviewing their suitability to be adoptive parents, contacting an agency, and preparing themselves for an interview. After the plan of action had been worked out, Raul and Maria, with the help of the counselor, identified two possible obstacles or pitfalls: the negative feelings that often arise on the part of prospective parents when they are being scrutinized by an adoption agency and the feelings of helplessness and frustration caused by the length of time and uncertainty involved in the process.

The assumption here is that if clients are aware of some of the “wrinkles” that can accompany any given course of action, they will be less disoriented when they encounter them. Identifying possible obstacles is, at its best, a straightforward exploration of likely pitfalls rather than a self-defeating search for every possible thing that could go wrong.

Obstacles can come from within the clients themselves, from others, from the social settings of their lives, and from larger environmental forces. Once an obstacle is spotted, counselors can help clients identify ways of coping with it. Sometimes simply being aware of a pitfall is enough to help clients mobilize their resources to handle it. At other times a more explicit coping strategy is needed. For instance, the counselor arranged two role-playing sessions with Raul and Maria in which she assumed the role of the examiner at the adoption agency and took a “hard line” in her questioning. These rehearsals helped them stay calm during the actual interviews. The counselor also helped them locate a mutual-help group of parents working their way through the adoption process. The members of the group shared their hopes and frustrations and provided support for one another. In short, Raul and Maria were trained to cope with the restraining forces they might encounter on the road toward their goal.

### **Help Clients Deal with Inertia**

Inertia is the human tendency to put off problem-managing action. I sometimes say to clients who I suspect are prone to inertia something like this, “The action program you’ve come up with seems to be a sound one. The main reason that sound action programs do not work, however, is that they are never tried. Do not be surprised if you feel reluctant to act or are tempted to put off the first steps. This is quite natural. Ask yourself what you can do to get by that initial barrier.” The sources of inertia are many, ranging from pure sloth to paralyzing fear. Understanding what inertia is like is easy. We need only look at our own behavior. The list of ways in which we avoid taking responsibility is endless. We will examine several of them here: passivity, learned helplessness, disabling self-talk, getting trapped in vicious circles, and disorganization.

**Passivity** One of the most important ingredients in the generation and perpetuation of the “psychopathology of the average” is passivity, the failure of people to take responsibility for themselves in one or more developmental areas of life or in various life situations that call for action. Passivity takes many forms: doing nothing—that is, not responding to problems and options; uncritically accepting the goals and solutions suggested by others; acting aimlessly; and becoming paralyzed—that is, shutting down or becoming violent, blowing up (see Schiff, 1975).

When Zelda and Jerzy first noticed small signs that things were not going right in their relationship, they did nothing. They noticed certain incidents, mused on them for a while, and then forgot about them. They lacked the communication skills to engage each other immediately and to explore what was happening. Zelda and Jerzy had both learned to remain passive before the little crises of life, not realizing how much their passivity would ultimately contribute to their downfall. Endless unmanaged problems led to major blowups until they decided to end their marriage.

Passivity in dealing with little things can prove very costly. Little things have a way of turning into big things.

**Learned helplessness** Seligman’s (1975, 1991) concept of “learned helplessness” and its relationship to depression is an important one (Garber & Seligman, 1980; Peterson, Maier, & Seligman, 1995). Some clients learn to believe from an early age that there is nothing they can do about certain life situations. There are degrees in feelings of helplessness—from mild forms of “I’m not up to this” to feelings of total helplessness coupled with deep depression. Learned helplessness, then, is a step beyond mere passivity.

Bennett and Bennett (1984) saw the positive side of helplessness. If clients’ problems are indeed out of their control, then it is not helpful for them to have an illusory sense of control, unjustly assign themselves responsibility, and indulge in excessive expectations. Somewhat paradoxically, they found that challenging clients’ tendency to blame themselves for everything actually fostered realistic hope and change.

The trick is helping clients learn what is and what is not in their control. A man with a physical disability may not be able to do anything about the disability itself, but he does have some control over how he views his disability and his power to pursue certain life goals despite it. The opposite of helplessness is “learned optimism” (Seligman, 1998) and resourcefulness. If helplessness can be learned, so can resourcefulness. Indeed, increased resourcefulness is one of the principal goals of successful helping. Optimism, however, is not an unmixed blessing; nor is pessimism always a disaster (Chang, 2001). Although optimists do live longer and enjoy greater success than pessimists, pessimists are better predictors of what is likely to happen. The price of optimism is being wrong a lot of the time. Perhaps we should help our clients be hopeful realists rather than optimists or pessimists.

**Disabling self-talk** Inviting clients to challenge their dysfunctional self-talk was discussed earlier. Clients often talk themselves out of things, thus talking themselves into passivity. They say to themselves such things as “I can’t do it,” “I can’t cope,” “I don’t have what it takes to engage in that program; it’s too hard,” and “It won’t

work.” Such self-defeating conversations with themselves get people into trouble in the first place and then prevent them from getting out. Helpers can add great value by helping clients challenge the kind of self-talk that interferes with action.

**Vicious circles** Pyszczynski and Greenberg (1987) developed a theory about self-defeating behavior and depression. They said that people whose actions fail to get them what they want can easily lose a sense of self-worth and become mired in a vicious circle of guilt and depression.

Consequently, the individual falls into a pattern of virtually constant self-focus, resulting in intensified negative affect, self-derogation, further negative outcomes, and a depressive self-focusing style. Eventually, these factors lead to a negative self-image, which may take on value by providing an explanation for the individual's plight and by helping the individual avoid further disappointments. The depressive self-focusing style then maintains and exacerbates the depressive disorder. (p. 122)

It does sound depressing. One client, Amanda, fits this theory perfectly. She had aspirations of moving up the career ladder where she worked. She was very enthusiastic and dedicated, but she was unaware of the “gentleman's club” politics of the company in which she worked and didn't know how to “work the system.” She kept doing the things that she thought should get her ahead. They didn't. Finally, she got down on herself, began making mistakes in the things that she usually did well, and made things worse by constantly talking about how she “was stuck,” thus alienating her friends. By the time she saw a counselor, she felt defeated and depressed. She was about to give up. The counselor focused on the entire “circle”—low self-esteem producing passivity producing even lower self-esteem—and not just the self-esteem part. Instead of just trying to help her change her inner world of disabling self-talk, he also helped her intervene in her life to become a better problem solver. Small successes in problem-solving led to the start of a “benign” circle—success producing greater self-esteem leading to greater efforts to succeed.

**Disorganization** Tico lived out of his car. No one knew exactly where he spent the night. The car was chaos, and so was his life. He was always going to get his career, family relations, and love life in order, but he never did. Living in disorganization was his way of putting off life decisions. Ferguson (1987, p. 46) painted a picture that may well remind us of ourselves, at least at times.

When we saddle ourselves with innumerable little hassles and problems, they distract us from considering the possibility that we may have chosen the wrong job, the wrong profession, or the wrong mate. If we are drowning in unfinished housework, it becomes much easier to ignore the fact that we have become estranged from family life. Putting off an important project—painting a picture, writing a book, drawing up a business plan—is a way of protecting ourselves from the possibility that the result may not be quite as successful as we had hoped. Setting up our lives to insure a significant level of disorganization allows us to continue to think of ourselves as inadequate or partially-adequate people who do not have to take on the real challenges of adult behavior.

Many things can be behind this unwillingness to get our lives in order, like defending ourselves against a fear of succeeding.

Driscoll (1984, pp. 112–117) has provided us with a great deal of insight into inertia. He described it as a form of control. He says that if we tell some clients

to jump into the driver's seat, they will compliantly do so—at least until the journey gets too rough. The most effective strategy, he claimed, is to show clients that they have been in the driver's seat all along: “Our task as therapists is not to talk our clients into taking control of their lives, but to confirm the fact that they already are and always will be.” That is, inertia, in the form of staying disorganized, is itself a form of control. The client is actually successful, sometimes against great odds, at remaining disorganized and thus preserving inertia. Once clients recognize their power, then we can help them redirect it.

### **Help Clients Deal with Entropy: The Tendency of Things to Fall Apart**

**Entropy** is the tendency to slow down and give up action that has been initiated. Kirschenbaum (1987), in a review of the research literature, uses the term “self-regulatory failure.” Programs for constructive change, even those that start strong, often dwindle and disappear. All of us have experienced problems trying to implement programs. We make plans, and they seem realistic to us. We start the steps of a program with a good deal of enthusiasm. However, we soon run into tedium, obstacles, and complications. What seemed so easy in the planning stage now seems quite difficult. We become discouraged, flounder, recover, flounder again, and finally give up, rationalizing to ourselves that we did not want to accomplish those goals anyway.

**False hopes** Under the rubric of “false hopes of self-change,” Polivy and Herman (2002) suggest that this scenario occurs all too frequently. Perhaps it is even the norm in self-change programs such as dieting, which they use as their point of reference. At the center of the false-hope syndrome, they say, are the clients' unrealistic expectations. They refer to things like New Year's Eve resolutions. Most of us can immediately think of many of our own resolutions that fell by the wayside. Fletcher (2003), Lowe (2003), and Snyder and Rand (2003) all quite vigorously challenge Polivy and Herman's findings and even the concept of “false hopes.” They say that the authors paint an overly pessimistic picture of self-change programs, especially dieting. That makes a priori sense if we consider outcome research in helping. When it comes to counseling, if we start with the premise that helping does help, then the kind of pessimism that Polivy and Herman suggest must be wrong. Right? Well, let's take a look.

We have already seen that hope and expectancy, on the part of both client and helper, are key ingredients in successful therapy. But substantive change is hard work. Even “true hope” can grow grey hairs in the face of adversity. That said, we should be able to help clients spot “false hopes” in their search for problem-managing outcomes. Expectancy is an ally only when it is realistic. We therapists will run across both true hopes and false hopes in our practice, but we will encourage the former and help clients challenge the latter. Even if the work of Polivy and Herman is as flawed as its critics say—and by the way, how could something so flawed end up in the *American Psychologist*?—there is something about it that rings true.

**Discretionary change** The track record of discretionary change—change that is not forced in one way or another—on the part of both individuals and institutions is poor. This is my read of individuals (including ourselves), companies, institutions, and countries. The change may not actually be discretionary, but if

it is seen, at whatever level of consciousness, as discretionary. If we think we do not have to change, then often we do not, even though we say we want to. In my (GE) work with organizations, I talk about the Okavango-Kalahari phenomenon. When the waters from the highlands in the north flood into the Okavango Delta in Botswana, it becomes an ecological wonderland. But somehow those waters disappear into the Kalahari Desert, though hydrologists do not know exactly how. I ask the managers, “Does this sound like any of your change programs?” They laugh. “Where’s that management development program you started so vigorously two years ago?” “In the Kalahari!” shouts one. I’m not sure that I have the Okavango-Kalahari hydrology right, but the challenge of discretionary change will always be with us. As you sit with clients, how much of the change being discussed is discretionary? “Forewarned is forearmed” is realism, not pessimism.

**The decay curve** Phillips (1987, p. 650) identified what he called the “ubiquitous decay curve” in both helping and in medical-delivery situations. Attrition, noncompliance, and relapse are the name of the game. A married couple trying to reinvent their marriage might eventually say to themselves, “We had no idea that it would be so hard to change ingrained ways of interacting with each other. Is it worth the effort?” Their motivation is on the wane. Wise helpers know that the decay curve is part of life and help clients deal with it. With respect to entropy, a helper might say, “Even sound action programs begun with the best of intentions tend to fall apart over time, so do not be surprised when your initial enthusiasm seems to wane a bit. That’s only natural. Rather, ask yourself what you need to do to keep yourself at the task.”

Brownell and her associates (1986) provided a useful caution. They drew a fine line between preparing clients for mistakes and giving them “permission” to make mistakes by implying that mistakes are inevitable. Preparation, yes; permission, no. They also made a distinction between “lapse” and “relapse.” A slip or a mistake in an action program (a lapse) need not lead to a relapse—that is, giving up the program entirely. Consider Graham, a man who has been trying to change what others see as his “angry interpersonal style.” Using a variety of self-monitoring and self-control techniques, he has made great progress in changing his style. On occasion, he loses his temper, but never in any extreme way. He makes mistakes, but he does not let an occasional lapse end up in relapse.

## Help Clients Avoid Imprudent Action

For some clients, the problem is not that they refuse to act but that they act imprudently. Rushing off to try the first strategy or tactic that comes to mind is often imprudent.

Elmer injured his back and underwent a couple of operations. After the second operation he felt a little better, but then his back began troubling him again. When the doctor told him that further operations would not help, Elmer was faced with the problem of handling chronic pain. It soon became clear that his psychological state affected the level of pain. When he was anxious or depressed, the pain always seemed much worse.

Elmer was talking this through with a counselor. One day he read about a pain clinic located in a western state. Without consulting anyone, he signed up for a



6-week program. Within 10 days he was back, feeling more depressed than ever. He had gone to the program with extremely high expectations because his needs were so great. The program was a holistic one that helped the participants develop a more realistic lifestyle. It included activities that focused on such things as nutrition, stress management, problem solving, and quality of interpersonal life. Group counseling was part of the program, and training was part of the group experience. For instance, the participants were trained in behavioral approaches to the management of pain.

The trouble was that Elmer had arrived at the clinic, which was located on a converted farm, with unrealistic expectations. He had bought a “packaged” program without studying the package carefully. Because he had expected to find marvels of modern medicine that would magically help him, he was extremely disappointed when he found that the program focused mainly on reducing and managing rather than eliminating pain.

Elmer’s goal was to be completely free of pain, but he failed to explore the realism of his goal. A more realistic goal would have centered on the reduction and management of pain. Elmer’s counselor failed to help him avoid two mistakes—setting an unrealistic goal and, in desperation, acting on the first strategy that came along. Obviously, action cannot be prudent if it is based on flawed assumptions—in this case, Elmer’s assumption that he could be pain free.

## Understand How Reluctance and Resistance Are Obstacles to Action **LO 8.3**

Helpers inevitably run into clients who are reluctant to engage in the often hard work needed to bring about problem-managing change. Helpers also encounter clients who not only drag their feet in the helping process but, sometimes vigorously, “push back” against any kind of helping at all or parts of the helping process. This is **resistance**. In these pages a distinction is made between reluctance and resistance although these two terms are often used interchangeably in the literature. Learning how to deal with “difficult” clients in general and with reluctance and resistance (both yours and the client’s) is an essential set of skills (Bonelli, 2017, <https://www.brightlocal.com/2017/05/09/how-to-handle-difficult-clients/>; Brodsky & Titcomb, 2013; Chapman & Rosenthal, 2016; Clay, 2017; Sullivan, 2014; Yep-Martin, <http://blog.time2track.com/working-with-challenging-clients-in-psychotherapy>).

### See Reluctance as Misgivings about Change

The seeds of reluctance are in the client. Managing problem situations and spotting and developing unused opportunities is hard work and the rewards for that work are not always immediately evident. Karl knows that he needs to get back into community. He talks to Laura about actions he thinks he should take such as reestablishing some kind of relationship with his local church, but he is slow in getting around to doing it. He talks the talk, but he keeps finding reasons for not walking the walk.

Being slow to seek help or accept help when it is offered is an early form of reluctance. Vogel, Wester, and Larson (2007) outline the main reasons why, in



terms of the beliefs, troubled people avoid helping in the first place. Here are some common beliefs:

- “Society looks down on those who seek help” (of course, some members of society do).
- “The whole experience will be too emotionally painful.”
- “Counseling probably won’t help me very much.”
- “I’ll have to reveal all my dark secrets.”
- “My family and friends will see me as odd.”
- “I’ll be embarrassed and feel worse about myself than I do now.”

For those who do work up the courage to see a helper, reluctance refers to their hesitancy to engage in the work demanded by the tasks of the helping process. Problem management and opportunity development involve a great deal of work. Therefore there are sources of reluctance in all clients—indeed, in all human beings. A great deal of effort may be involved in trying to rehabilitate or save a failing marriage. Conquering an addiction is hard work. Some people “give up” smoking dozens of times before finally succeeding. Unused opportunities also provide challenges. Developing unused opportunities means venturing into unknown waters. Although this is a charming idea for some, it strikes something akin to terror in others. Socially shy clients often enough choose living a lonely life than taking even small steps toward establishing real friendship. One client who acquired dozens of “friends” on Facebook but never met any of them in person became deeply depressed over her “make-believe” social life. She referred to herself as an “Internet fraud.”

Clients exercise reluctance in many, often covert, ways. They talk about only safe or low-priority issues, seem unsure of what they want, benignly sabotage the helping process by being overly cooperative, set unrealistic goals and then use them as an excuse for not moving forward, do not work very hard at changing their behavior, and are slow to take responsibility for themselves. They tend to blame others or the social settings and systems of their lives for their troubles and play games with helpers. Or they do not come for counseling in the first place. For instance, Tim is reluctant to join his wife in her sessions with a counselor. He says that he’ll “think about it,” that he doesn’t feel “any real need” to talk to a counselor, that right now the demands of his job are too pressing and that he can’t “find the time” for the sessions, and so forth. Deep down he’s afraid of what might happen were he to go. There are many ways clients drag their feet. We need only to reflect our own experience. Reluctance to change is normal. Reluctance also admits of degrees; clients come “armored” against change to a greater or lesser degree. The reasons for reluctance are many. They are built into the human condition. Here is a sampling.

***Fear of intensity*** If the counselor uses high levels of tuning in, listening, sharing empathic highlights, and probing, and if the client cooperates by exploring the feelings, experiences, behaviors, points of view, and intentions related to his or her problems in living, the helping process can be an intense one. This intensity can cause both helper and client to back off. Skilled helpers

know that counseling is potentially intense. They are prepared for it and know how to support a client who is not used to such intensity. They certainly know when to back off.

**Lack of trust** Some clients find it very difficult to trust anyone, even a most trustworthy helper. They have irrational fears of being betrayed. Even when confidentiality is an explicit part of the client-helper contract, some clients are very slow to reveal themselves. A combination of patience, encouragement, and invitations to self-challenge is demanded of the helper.

**Fear of self-exploration** Some people fear self-disclosure because they feel that they cannot face what they might find out about themselves. The client feels that the façade he or she has constructed, no matter how much energy must be expended to keep it propped up, is still less burdensome than exploring the unknown. Such clients often begin well but retreat once they start to be overwhelmed by the data produced in the problem-exploration process. Digging into one's inadequacies always leads to a certain amount of disequilibrium, disorganization, and crisis. But breakthroughs and growth often take place at crisis points. That said, a high degree of disorganization immobilizes the client, whereas very low disorganization is often indicative of a failure to get at the client's core concerns. By inviting clients to take "baby steps" that do not end in disaster, counselors help clients build confidence.

**Shame** Shame is a much overlooked variable in human living (Bradshaw, 2005; Brown, 2007; Kaufman, 1989; Lynd, 1958; M. Miller, Retrieved 2008; Myers, 2017; Nathanson, 1987). Dearing and Tangney (2011) have edited a book that looks at shame from many different points of view. Shame can be an important part of disorganization and crisis. The root meaning of the verb to shame is "to uncover, to expose, to wound," a meaning that suggests the process of painful self-exploration. Shame is not just being painfully exposed to another; it is primarily an exposure of self to oneself. In shame experiences, particularly sensitive and vulnerable aspects of the self are exposed, especially to one's own eyes. Shame is often sudden—in a flash, the client sees heretofore unrecognized inadequacies without being ready for such a revelation. Shame is sometimes touched off by external incidents, such as a casual remark someone makes, but it could not be touched off by such insignificant incidents unless, deep down, one was already ashamed.

A shame experience might be defined as an acute emotional awareness of a failure to *be* in some way. Farber and Shon (2007) observe that shame is often an obstacle to frank discussions of sexuality: "Sexuality is the least extensively disclosed theme in psychotherapy and the second least discussed item within marriage. . . . Even the relative safety and the near-absolute confidentiality of the therapist's office are not sufficient at times to overcome the shame in discussing this most personal issue" (p. 230). Of course, empathy and support help clients deal with whatever shame they might experience. But shame is not limited to issues concerning sexuality. It is often an issue in clients with substance-abuse

problems (Potter-Efron, 2011) and PTSD disorders (Herman, 2011). Laura realizes early on that Karl felt deeply ashamed about letting down his comrades, the army, and his country. He covered this over with a great deal of bravado, but when he was counseled to accept an honorable discharge, he felt strangely relieved because he knew he “deserved” to be let go.

The diversity issue makes helping clients deal with reluctance more difficult. Research findings on one population do not automatically transfer to another (Furukowa & Hunt, 2011). Some individuals or even populations may well be glad to share the most intimate details of their personal lives without experiencing any shame or other debilitating emotion. On the other hand, some more conservative cultures abhor the thought of discussing intimate issues. Recall the guidelines for dealing with diversity outlined in Chapter 3.

***The cost of change*** Some people are afraid to take stock of themselves because they know, however subconsciously, that if they do, they will have to change—that is, surrender comfortable but unproductive patterns of living, work more diligently, suffer the pain of loss, acquire skills needed to live more effectively, and so on. For instance, a husband and wife may realize, at some level, that if they see a counselor, they will have to reveal themselves and that once the cards are on the table, they will have to go through the agony of changing their style of relating to each other. Some clients come with the assumption that counseling is magic and are put off when change proves to be hard work. In cases like this, counselors need to help clients see that the outcomes are worth the effort. It took one client several years to quit smoking, but when she finally did so she told everyone who would listen, “I just love the sense of freedom I have now. I was a prisoner, but now I’m free. Why did I wait so long?” We know why.

***A loss of hope*** Some clients think that change is impossible, so why try? A man in his 60s, a participant in a counseling group, complained about constant anxiety. He had given up hope. How could anyone who had been treated as brutally as he was by his father have any hope? Running away from home was just the beginning. He kept running from hope the rest of his life. But after being challenged by both helper and his fellow participants, he rediscovered hope and, with it, self-responsibility. He no longer focused on the “scars” inflicted by his father’s mistreatment. He no longer focused on the self-inflicted scars of a life lived irresponsibly. He found hope in both the care he experienced in the group and the life struggles revealed by the other participants. He found hope in community.

This is just a sampling. We need only to look at our own struggles with growth, development, and maturity to add to the list.

## **See Resistance as Reacting to Coercion**

Clients who resist tend to think that they are being forced to do something. They may even want to engage in therapy or in some therapeutic exercise, but feel that their helpers are demanding participation rather than inviting them to participate. When Laura suggested that Karl use the feedback surveys, Karl said no because he experienced her invitation as a demand. Later on he told her that at the time he felt that she was more or less saying, “Be a good boy and fill

these surveys out for me.” Of course that was not Laura’s intention, but she in no way tried to impose the surveys on him. There were other collaborative ways of introducing feedback into the helping process.

***Reacting to perceived mistreatment*** Clients who think that they are being mistreated by their helpers in some way tend to resist. Clients who believe that their cultural beliefs, values, and norms—whether group or personal—are being violated by the helper can be expected to resist. Resistance is the client’s way of fighting back (Dimond et al., 1978; Driscoll, 1984). Spouses who feel forced to come to marriage counseling sessions are often resistant. They resist because they resent what they see as a power play. Tony gets angry when his wife suggests that he come with her to her counseling sessions. Knowing that she has talked this over with her mother, he feels that he is the focus of a conspiracy. They are looking for ways to coerce him to go. “I don’t care what happens, but they’re not going to get me,” are his sentiments. Of course, some clients see coercion where it does not exist. But because people act on their perceptions, the result is still some form of covert or open fighting back.

Resistant clients, feeling abused, let everyone know that they have no need for help, show little willingness to establish a working relationship, and often enough try to con counselors. They are often resentful, make active attempts to sabotage the helping process, or terminate the process prematurely. They can be either testy or actually abusive and belligerent. Resistance to helping is, of course, a matter of degree, and not all resistant clients engage in extreme forms of resistance behaviors.

***Involuntary clients*** Involuntary clients (Brodsky, 2011)—sometimes called “mandated” clients—are often resisters. A high school student gets into trouble with a teacher and sees being sent to a counselor as a form of punishment. A felon receives probation on the condition of being involved in some kind of counseling process. A manager accused of sexual harassment keeps his job only if he agrees to a series of counseling sessions. Clients like these are found in schools, especially schools below college level, in correctional settings, in marriage counseling, especially if it is court-mandated, in employment agencies, in welfare agencies, in court-related settings, and in other social agencies. But any client who feels that he or she is being coerced or treated unfairly can become a resister. Clients can experience coercion in a wide variety of ways. The following kinds of clients are often resistant.

- Clients who see no reason for going to the helper in the first place.
- Clients who resent third-party referrers (parents, teachers, correctional facilities, and social service agencies) and whose resentment carries over to the helper.
- Clients who do not know what helping is about and fear the unknown.
- Clients who have a history of rebelliousness.
- Clients who see the goals of the helper or the helping system as different from their own. For instance, the goal of counseling in a welfare setting may be to help clients become financially independent, whereas some clients may be satisfied with financial dependency.

- Clients who have developed negative attitudes about helping and helping agencies and who harbor suspicions about helping and helpers. They do not trust “shrinks.”
- Clients who believe that going to a helper is the same as admitting weakness, failure, and inadequacy. They feel that they will lose face by going. By resisting the process, they preserve their self-esteem.
- Clients who feel that counseling is something that is being done to them. They feel that their rights are not being respected.
- Clients who feel a need for personal power and find it through resisting a powerful figure or agency. “I may be relatively powerless, but I still have the power to resist” is the subtext.
- Clients who dislike their helpers but do not discuss their dislike with them.
- Clients who differ from their helpers about the degree of change needed.
- Clients who differ greatly from their helpers—for instance, a poor kid with an older middle-class helper.

Kiracofe and Wells (2007) object to mandated or disciplinary counseling, at least in educational institutions, on both professional and ethical grounds. For instance, they claim that disciplinary counseling muddies the issue of self-responsibility: “An implied assumption of the mandatory referral is that disruptive behavior can be managed and changed as a result of regular counseling sessions. This assumption, in effect, removes the responsibility for behavior change from the student and places it on the counseling process” (p. 263). They offer a set of strategies for judicial action based on disruptive students’ readiness for change that are aligned with Prochaska’s readiness for change stages outlined in Part III. Student misconduct is not going to go away and both teachers and administrators have been traditionally too ready to pass the buck. Kiracofe and Wells’s article calls for a more professional debate and a systemic solution.

Many sociocultural variables—gender, prejudice, race, religion, social class, upbringing, cultural and sub cultural blueprints, and the like—can play a part in resistance. For instance, a man might instinctively resist being helped by a woman and vice versa. An African American person might instinctively resist being helped by a white person and vice versa. A person with no religious affiliation might instinctively think that help coming from a minister will be “pious” or will automatically include some form of proselytizing. In the end it’s your job to spot resistance and work with the client to determine what is causing it.

**Healthy resistance** Of course, resistance can be a healthy sign. It can mean that clients are standing up for their rights and fighting back. Koenig (2011) makes an excellent point. Although he is talking about patients who resist the recommendations of medical doctors, what he says applies also to therapy clients. Resistance creates an opportunity for collaborative decision making: “Through resistance to a treatment recommendation, patients work to negotiate and collaboratively co-construct what counts as an acceptable recommendation”(p. 1105). That is, through resistance clients become agents, negotiating or fighting for what they need.

In practice, of course, a mixture of reluctance and resistance is often found in the same client. If therapy is to become more efficient, then counselors need to find ways of helping their clients deal with reluctance and resistance as expeditiously as possible.

## Use Guidelines for Helping Clients Deal with Reluctance and Resistance

LO 8.4

Because both reluctance and resistance are such pervasive phenomena, helping clients manage them is part and parcel of all our interactions with clients (Kottler, 1992). Here are some principles.

### Avoid Unhelpful Responses to Reluctance and Resistance

Helpers, especially beginning helpers who are unaware of the pervasiveness of reluctance and resistance, are often disconcerted when they encounter uncooperative clients. Such helpers are prey to a variety of emotions—confusion, panic, irritation, hostility, guilt, hurt, rejection, and depression. Distracted by these unexpected feelings, they react in any of several unhelpful ways.

- They accept their guilt and try to placate the client.
- They become impatient and hostile and manifest these feelings either verbally or nonverbally.
- They do nothing in the hope that the reluctance or the resistance will disappear.
- They lower their expectations of themselves and proceed with the helping process, but in a halfhearted way.
- They try to become warmer and more accepting, hoping to win the client over by love.
- They blame the client and end up in a power struggle with him or her.
- They allow themselves to be abused by clients, playing the role of a scapegoat.
- They lower their expectations of what can be achieved by counseling.
- They hand the direction of the helping process over to the client.
- They give up.

In short, when helpers engage “difficult” clients, they experience stress, and some give in to self-defeating “fight or flight” approaches to handling it.

The source of this stress is not just clients’ behavior; it also comes from the helper’s own self-defeating attitudes and assumptions about the helping process. Here are some of them.

- All clients should be self-referred and adequately committed to change before appearing at my door.
- Every client must like me and trust me.
- I am a consultant and not a social influencer; it should not be necessary to place demands on clients or even help them place demands on themselves.
- Every unwilling client can be helped.
- No unwilling client can be helped.
- I alone am responsible for what happens to this client.
- I have to succeed completely with every client.

These unrealistic beliefs are never spoken, but they can linger in the background. Effective helpers neither court reluctance and resistance nor are surprised by them.

### **Develop Productive Approaches to Dealing with Reluctance and Resistance**

In a book like this, it is impossible to identify every possible form of reluctance and resistance, much less provide a set of strategies for managing each. Here are some principles and a general approach to managing reluctance and resistance in whatever forms they take.

***Explore your own reluctance and resistance*** Examine reluctance and resistance in your own life. How do you react when you feel coerced? What do you do when you feel you are being treated unfairly? How do you run away from personal growth and development? If you are in touch with the various forms of reluctance and resistance in yourself and are finding ways of overcoming them, you are more likely to help clients deal with theirs.

***See some reluctance and resistance as normal*** Help clients see that their reluctance and resistance are not “bad” or odd. After all, yours isn’t. Beyond that, help them see the positive side of resistance. It may well indicate that they have fiber. It may be a sign of self-affirmation.

***Accept and work with the client’s reluctance and resistance*** Teyber (2005) talks about “honoring” the client’s resistance. This is a central principle. Start with the client’s frame of reference. Accept both the client and his or her reluctance or resistance. Do not ignore it or be intimidated by what you find. Let clients know how you experience it and then explore it with them. Model openness to challenge. Be willing to explore your own negative feelings. The skill of direct, mutual talk (called immediacy), discussed in Chapter 7, is extremely important here. Help clients work through the emotions associated with reluctance and resistance. Avoid moralizing. Befriend the reluctance or the resistance instead of reacting to it with hostility or defensiveness.

***See reluctance as avoidance*** Reluctance is a form of avoidance that is not necessarily tied to client ill will. Therefore you need to understand the principles and mechanisms underlying avoidance behavior, which is often discussed in texts dealing with the principles of behavior (Watson & Tharp, 2013). Some clients avoid counseling or give themselves to it only halfheartedly because they see it as lacking in suitable rewards or even as punishing. If that is the case, then counselors have to help them search for suitable incentives. Constructive change is usually more rewarding than a miserable status quo, but that might not be the client’s perception, especially in the beginning. Find ways of presenting the helping process as rewarding. Talk about outcomes.

***Examine the quality of your interventions*** Without setting off on a guilt trip, examine your helping behavior. What are you doing that might seem unfair to the client? In what ways does the client feel coerced? For example, you may have



become too directive without realizing it. Furthermore, take stock of the emotions that are welling up in you because clients lash back or drag their feet. How are these emotions “leaking out”? No use denying such feelings. Rather, own them and find ways of coming to terms with them. Do not over personalize what the client says and does. If you are allowing a hostile client to get under your skin, you are probably reducing your effectiveness. Of course, the client might be resistant, not because of you, but because he is under pressure from others to deal with his problems. But you take the brunt of it. Find out, if you can.

***Be realistic and flexible*** Remember that there are limits to what a helper can do. Know your own personal and professional limits. If your expectations for growth, development, and change exceed the client’s, you can end up in an adversarial relationship. Rigid expectations of the client and of yourself become self-defeating.

***Establish a “just society” with your client*** Deal with the client’s feelings of coercion. Provide what Smaby and Tamminen (1979) called a “two-person just society” (p. 509). A just society is based on mutual respect and shared planning. Therefore establish as much mutuality as is consonant with helping goals. Invite participation. Help clients participate in every step of the helping process and in all the decision making. Share expectations. Discuss and get reactions to helping procedures. Explore the helping contract with your clients and get them to contribute to it.

***Help the client search for incentives for moving beyond resistance*** Help the client find incentives for participating in the helping process. Use client self-interest as a way of identifying these. Use brainstorming as a way of discovering possible incentives. For instance, the realization that he or she is going to remain in charge of his or her own life may be an important incentive for a client.

***Do not see yourself as the only helper in your client’s life*** Engage significant others, such as peers and family members, in helping the client face reluctance and resistance. For instance, lawyers who belong to Alcoholics Anonymous may be able to deal with a fellow lawyer’s reluctance to join a treatment program more effectively than you can.

***Employ reluctant and resistant clients as helpers*** If possible, find ways to get a reluctant or resistant client into situations to help others. The change of perspective can help the client come to terms with his or her own unwillingness to work. One tactic is to take the role of the client in the interview and manifest the same kind of reluctance or resistance he or she does. Have the client take the counselor role and help you overcome your unwillingness to work or cooperate. One person who did a great deal of work for Alcoholics Anonymous had a resistant alcoholic go with him on his city rounds, which included visiting hospitals, nursing homes for alcoholics, jails, flophouses, and down-and-out people on the streets. The alcoholic saw through all the lame excuses other alcoholics offered for their plight. After a week, he joined AA himself. Clients can become helpers in group counseling, too.

Hanna, Hanna, and Keys (1999; see also Hanna, 2002; and Sommers-Flanagan & Sommers-Flanagan, 2007) drew up a list of fifty strategies—some original, many drawn from the helping literature—for counseling defiant, aggressive adolescents. Many of the strategies have wider application to both reluctant and resistant clients of all ages and can be used to put into practice the principles outlined above. The authors divide the strategies into three categories: reaching clients, accepting them, and relating to them. As you read through their suggestions, it soon becomes clear that they are talking about what helpers should be doing as a matter of course. But their lists are excellent reminders.

Reluctance and resistance create challenges for both clients and helpers. Helping clients overcome, deal with, or come to terms with different forms of unwillingness is often at the heart of helping. Do not be surprised when clients react strongly when invited to challenge themselves. If they react negatively rather than respond, then you have to find ways of helping them work through their emotion-laden reluctance and resistance. If they seem to “clam up,” try to find out what’s going on inside. In the following example, the helper has just delivered a brief summary of the main points of the problem situation they have been discussing, gently pointing out the self-destructive nature of some of the client’s behaviors.

**HELPER:** I’m not sure how all this sounds to you.

**CLIENT:** I thought you were on my side. Now you sound like all the others. And I’m paying you to talk like this to me!

Even though the helper was tentative in her invitation to self-challenge based on what the client had already said about himself, the client still reacted defensively. Here are two different approaches (A and B) to the client’s defensiveness.

**HELPER A:** All I’ve done is summarize what you have been saying about yourself. And you know you’re doing yourself in. Let’s look at each point we’ve been discussing and see if this isn’t the case.

This helper responds with a defensive, judicial approach. He’s about to assemble the evidence. This would probably lead to an argument rather than further dialogue. Helper B backs off a bit.

**HELPER B:** So, I’m sounding harsh and unfair to you. . . . Kind of dumping on you. . . . Let’s back up.

This helper backs off without saying that her summary was wrong. She is giving the client some space. It may be that the client needs time to think about what the helper has said. Helper B tries to find a way into a constructive dialogue with the angered client.

Some call clients who are reluctant, resistant, and/or slow to tap into the **resilience** within themselves difficult clients. There is also a tendency to see difficult clients as bad clients. But they are just clients. Wessler, Hankin, and Stern (2001) evened the therapy playing field by suggesting that the term “difficult client” is too one-sided. The therapist is often enough part of the difficulty: “When a therapist uses the word ‘difficult’ to describe a client, what he or she really means is: ‘I am having difficulty working with this person due to either my own emotional

issues or a lack of experience working with clients like this.’ In essence, using the word difficult to describe a client should be a signal to the therapist that he/she needs to grow in some way personally (and interpersonally)” (p. 5). Fair enough, but clients come for help precisely because they are not managing some part of their lives effectively. Their behavior in the helping sessions is often enough an indication of or an example of poor self-management. It is impossible to be in the business of helping people for long without encountering both reluctance and resistance. The literature is scattered all over the place (Brodsky, 2011; McKay, Abramowitz, & Taylor, 2010; Mitchell, 2006; Rasmussen, 2002; Westra, 2004; Westra et al., 2011). Predictably, some of the findings and recommendations conflict with one another. You need to use the values outlined in Part I and the communication skills outlined in Part II of this book to find ways to help clients who, at least at first sight, do not want to be helped.

### **Avoid Helper Reluctance and Resistance**

Driscoll (1984, pp. 91–97) discussed the temptation of helpers to respond to the passivity of their clients with a kind of passivity of their own, a “sorry, it’s up to you” stance. This, he claimed, is a mistake.

A client who refuses to accept responsibility thereby invites the therapist to take over. In remaining passive, the therapist foils the invitation, thus forcing the client to take some initiative or to endure the silence. A passive stance is therefore a means to avoid accepting the wrong sorts of responsibility. It is generally ineffective, however, as a long-run approach. Passivity by a therapist leaves the client feeling unsupported and thus further impairs the already fragile therapeutic alliance. Troubled clients, furthermore, are not merely unwilling but generally and in important ways unable to take appropriate responsibility. A passive countermove is therefore counterproductive, for neither therapist nor client generates solutions, and both are stranded together in a muddle of entangling inactivity. (p. 91)

To help others act, helpers must be agents and doers in the helping process, not mere listeners and responders. The best helpers are active in the helping sessions. They keep looking for ways to enter the worlds of their clients, to help them become more active in the sessions, to help them own more of the constructive change process, to help them see the need for action—action in their heads and action outside their heads in their everyday lives. And they do all this while espousing the client-centered values outlined in Chapter 3. Although they do not push reluctant clients too hard, thus turning reluctance into resistance, neither do they sit around waiting for reluctant clients to act.

## **Help Clients Tap into Their Resilience, the Ability to Bounce Back and Grow**

**LO 8.5**

A great deal is currently being written about the importance of resilience in counseling and therapy. A bias toward action is at the heart of resilience. Consider the following case.

Juliana was a headstrong girl right from the start. High school was a bit tumultuous, but the seeds of really significant problems were sown during her college years.

There she learned both the pleasures and the misery of drugs. Because her friends were “druggies,” she chose boyfriends who were also playing with drugs and who could accommodate her headstrong nature. Predictably, boyfriends came and went. The drugs were a constant. After college she stuck to this lifestyle. Now boyfriends and jobs came and went.

Her parents loved her dearly and did everything they could to help her. She played them like a harp. At times she would give hints that she was tired of her lifestyle, and their hopes were raised. Then she plunged back into her old ways with a vengeance. Her parents were always there for her. In a sense, this was part of the problem situation. Their financial and social support allowed her to continue in her unhealthy ways. After some sessions with a counselor, her parents decided to cut her loose. She had to leave the house and make her own way financially. This ripped them apart but they did not know what else to do.

Off Juliana went. The ensuing picture was not pretty at all. It almost seemed that she was going to get even worse as a way of getting back at her parents. To their horror, she ended up in jail. But jail seemed to be the turning point. After getting out, she stopped taking drugs. She got a number of jobs, but her headstrong nature still asserted itself. She moved from job to job either because she could not stand the people at work or because people could no longer put up with her. She was really shaken up when her father lost his job. By then she had reestablished some kind of minimal relationship with her family. She began to see a counselor again. He soon recognized a number of Juliana’s inner resources. Headstrong, yes, but a woman with guts, too. A woman who could not seem to establish reasonable relationships with others—especially men—but also a woman with a keen understanding of human nature. In spite of all the messy years she had not lost her spark, and her rather substantial inner resources were hidden but intact.

Juliana finally nailed down a job she liked, was promoted, was headhunted by another company, but stayed with the original one because she got a better position in that company with better pay. She established a home for her two children who had been farmed out to relatives. She subscribed to and promoted the values, such as self-discipline and decency in interpersonal relationships, which her children had learned in their foster homes. She reestablished full contact with her family. She became a caring companion to the man with whom she lived. In short, she successfully rejoined the community she had abandoned.

The counselor played a catalytic role in this process of renewal, but Juliana did the work. She has a pronounced bias to action. He encouraged her to tap into the wellspring of resilience or hardiness (Khoshaba & Maddi, 2004; Maddi, 2002) or growth-through-adversity (Jeseph & Linley, 2005) inside her, and she did. She moved from self-loathing to a nonindulgent form of self-esteem. Success in one area of life (work) spread to others (interpersonal relationships). Like many converts, she even became a crusader with her children, relatives, and friends for hard work, self-discipline, and the total avoidance of self-pity. The point is that even in the most difficult cases, there is probably some residue of resilience. Tapping into it is the challenge. Years have passed. Did Juliana stay the course? Yes, to this day!

### **Help Clients Discover Their Resilience**

A bias toward action is based on resilience. Though buried under despair, resilience is found even in some of the most desperate clients. There has been a mini-explosion of theory and research about resilience (Alvord &

Grados, 2005; Bonanno, 2004, 2005; Flach, 1997; T. Kelley, 2005; Linley & Joseph, 2005; Litz, 2005; Maddi, 2005; Reivich & Shatt , 2002; Tedeschi & Kilmer, 2005; Tugade & Fredrickson, 2004), and the American Psychological Association has even launched a “resilience initiative” (Kersting, 2003, 2005; Newman, 2005). Newman defines resilience as “the human ability to adapt in the face of tragedy, trauma, adversity, hardship, and ongoing significant life stressors” (p. 227). For a summary of basic common sense about resilience you might well read “The Road to Resilience” (American Psychological Association, [www.apa.org/helpcenter/road-resilience.aspx/#](http://www.apa.org/helpcenter/road-resilience.aspx/#)). A full Internet search will overwhelm you. Glicken (2006) first takes a stab at cataloguing the attributes of resilience, then, realizing that research and “science” have such a long way to go in this area, ends up by letting examples of resilience speak eloquently for themselves.

### Encourage Both Bounce-Back Action and Steady-State Action

The ability to bounce back is an essential life capability. Holaday and McPhearson (1997) have compiled a list of common factors that influence resilience. Although they focused on severe-burn survivors, their discussion of resilience applies to all of us and our clients. They distinguish between outcome resilience and process resilience. Whereas resilience in general is the ability to overcome or adapt to significant stress or adversity, *outcome resilience* implies a return to a previous state. This is “bounce back” resilience. Dora goes through the trauma of divorce, but within a few months she bounces back. Her friends say to her, “You seem to be your old self now.” She replies, “Both older and wiser.” *Process resilience*, on the other hand, represents the continuous effort to cope that is a “normal” part of some people’s lives. Both are important. The burn survivors in Holaday and McPhearson’s study would say such things as, “Resilience? It’s my spirit and it’s the reason I’m here,” “[Resilience] is deep inside of you, it’s already there, but you have to use it,” and “To do well takes a lot of determination, courage, and struggling, but it’s your choice” (p. 348).

You can encourage both kinds of resilience in clients. Let’s start with outcome resilience. Kerry finds himself in a financial mess because of a tendency to be a spendthrift and because of a few poor financial decisions. He seeks out a financial counselor who understands the dynamics of resilience. He helps Kerry review the mistakes that have been his downfall and guides him along the sometimes painful path to recovery. Although Kerry makes a couple more mistakes, he gradually works his way out of the mess. It takes more than two years. Along the way he is tempted more than once to declare bankruptcy, but the counselor helps him review the financial consequences. The ads inviting people to declare bankruptcy do not mention the downside. He gets depressed at times but talks it through with his counselor. Once he is back on his feet, Kerry spends a bit more time with the counselor on prevention strategies. A society in which the media focus on, and even idolize, the super rich is filled with temptations to pursue easy money. Kerry puts himself on a strict budget and things stabilize. It’s not difficult for him to walk the financial straight and narrow because the mess has been too painful to repeat. He prides himself on being financially stable.

Process resilience is another matter. Oscar finds that controlling his anger is a constant struggle. He has to keep finding the process-resilience resources within himself needed to keep plugging away. And then there is Nadia, a middle-aged single woman suffering from chronic fatigue syndrome. She has to dig deep within herself every day to find the will to go on. Like many people suffering from this condition, she wants to do her best and even make a good impression (Albrecht & Wallace, 1998). On the days she's successful in pulling herself together, the people she meets cannot believe that she is ill. For her, running into this kind of disbelief is a two-edged sword. On the one hand, her affliction is so painful that she wonders how intelligent people could possibly not notice. On the other hand, she realizes that working hard at showing her best face to the world and often enough succeeding in doing so is a victory.

### Understand Factors Contributing to Resilience

Holaday and McPhearson (1997) suggest that care factors that influence resilience include social support, cognitive skills, and psychological resources. Certain personality characteristics or dispositions protect people from stress and contribute to "bounce back." They include an internal locus of control, empathy, curiosity, a tendency to seek novel experiences, a high activity level, flexibility in new situations, a sense of humor, the ability to elicit positive regard from others, accurate and positive self-appraisal, personal integrity, a sense of self-protectiveness, pride in accomplishments, and a capacity for fun. Here are some examples.

- *Social support* got one burn victim going. He said, "I wanted to give up, but my wife would have none of it. She made me get out of the hospital bed and learn to walk again." As we have seen, your job is to help clients identify, create, and tap into social support.
- The ability to use *fantasy and hope* helps some clients spring back. Fantasy can distract clients from their misery and therefore use whatever resources they have to move forward. One client, in misery because one of his best friends "stole" the girl to whom he was engaged, told me, "A long time ago I learned how to deal with chronic back pain by distracting myself from it. I used fantasy a lot and it helped. The pain right now is psychological and it's worse. I'm almost addicted to my pain. I want to find a way to use fantasy again." And we have already seen the power of hope. One marine who lost both his legs said, "I'll run again." And he did.
- A "*belligerent style*" (Zimrin, 1986), rather than a passively enduring, accepting, or yielding style, often contributes more to resilience. One of my clients, a "pleasant" woman in her early 40s, lost her husband to another woman. She moved from being "pleasant" to being very assertive. She did not run roughshod over the rights of others, but she did fight for her own. Some of her friends found it hard to interact with the "new" Geraldine, but her new interpersonal style helped her create a new life.
- Some clients find resilience in new-found ability to *discuss feelings*. One burn survivor said, "Sometimes I still choose to feel sorry for myself and have a bad day, and that's OK."



- Another useful coping strategy for some is *avoiding self-blame* and using the *energy of anger* to cope with the world rather than damage the self. One client, who had been severely burned as a child, said, “When I was little, I wanted the scars to go away, but now I don’t care about them any more. They’re part of me. I’ve stopped apologizing for myself.”
- The way clients exercise *personal control* in their lives and how they *interpret* their experiences can contribute to their resilience. One client who fell off the wagon and got drunk for a couple of days said, “It’s a glitch, not a pattern. I can expect a glitch now and again. Glitches can be dealt with. Patterns are damaging.” He was no longer a drunk. For the most part he controlled alcohol rather than vice versa. “I’m certainly not a drunk but sometimes I’m no better than a lot of others.”

As these examples attest, resilience is not always a “pretty picture.” Different theoreticians and researchers continue to name different sets of factors that contribute to resilience (Van Vliet, 2008). But there is, at least not yet, no “scientific” set of such factors. But the growing literature (and life itself) suggests that there is a range of “resilience levers” in every client. Your job is to help clients discover and pull them together in order to bounce back. Resilience is “deep inside” your clients. It’s part of their self-healing nature. The communication skills described and illustrated earlier are essential for helpers. With them therapists help clients tap into the pool of resilience found, to a greater or lesser extent, in and around every human being.

The American Psychological Association in its publication *The Road to Resilience* suggests the following steps to developing resilience.

***Make connections*** Good relationships with close family members, friends, or others are important. Accepting help and support from those who care about you and will listen to you strengthens resilience. Some people find that being active in civic groups, faith-based organizations, or other local groups provides social support and can help with reclaiming hope. Assisting others in their time of need also can benefit the helper.

***Avoid seeing crises as insurmountable problems*** You cannot change the fact that highly stressful events happen, but you can change how you interpret and respond to these events. Try looking beyond the present to how future circumstances may be a little better. Note any subtle ways in which you might already feel somewhat better as you deal with difficult situations.

***Accept that change is a part of living*** Certain goals may no longer be attainable as a result of adverse situations. Accepting circumstances that cannot be changed can help you focus on circumstances that you can alter.

***Move toward your goals*** Develop some realistic goals. Do something regularly—even if it seems like a small accomplishment—that enables you to move toward your goals. Instead of focusing on tasks that seem unachievable, ask yourself, “What’s one thing I know I can accomplish today that helps me move in the direction I want to go?”



**Take decisive actions** Act on adverse situations as much as you can. Take decisive actions, rather than detaching completely from problems and stresses and wishing they would just go away.

**Look for opportunities for self-discovery** People often learn something about themselves and may find that they have grown in some respect as a result of their struggle with loss. Many people who have experienced tragedies and hardship have reported better relationships, greater sense of strength even while feeling vulnerable, increased sense of self-worth, a more developed spirituality and heightened appreciation for life.

**Nurture a positive view of yourself** Developing confidence in your ability to solve problems and trusting your instincts helps build resilience.

**Keep things in perspective** Even when facing very painful events, try to consider the stressful situation in a broader context and keep a long-term perspective. Avoid blowing the event out of proportion.

**Maintain a hopeful outlook** An optimistic outlook enables you to expect that good things will happen in your life. Try visualizing what you want, rather than worrying about what you fear.

**Take care of yourself** Pay attention to your own needs and feelings. Engage in activities that you enjoy and find relaxing. Exercise regularly. Taking care of yourself helps to keep your mind and body primed to deal with situations that require resilience.

**Additional ways of strengthening resilience may be helpful** For example, some people write about their deepest thoughts and feelings related to trauma or other stressful events in their life. Meditation and spiritual practices help some people build connections and restore hope.

The key is to help clients identify ways that are likely to work well as part of their own personal strategy for fostering resilience.

### **Note the Relationship of Resilience to Posttraumatic Growth**

It is helpful to revisit posttraumatic growth discussed in Chapter 7. Posttraumatic growth is the outcome of resilience. Here are a few more examples. Phillips and Daniluk (2004), in exploring the stories of seven adult women who had experienced sexual abuse as children, found that a “strong sense of resiliency and growth was a persistent theme that wove itself throughout the interviews” (p. 181). One of the women said: “I wouldn’t wish the pain of child abuse on anybody, but I realize that if I hadn’t been abused or been through hell like that, I might never have known how unlimited the human spirit is around finding its way through impossible odds. I wouldn’t have missed the experience of learning that for the world” (p. 182). Bogar and Hulse-Killacky (2006), in a study of ten women who had been sexually abused as children, discovered what they call “resiliency determinants” (interpersonally skilled, competent, high self-regard,

spiritual, and helpful life circumstances) and “resiliency processes” (coping strategies, refocusing and moving on, active healing, and achieving closure) that facilitated resiliency in these women’s adult lives. Rendon (2015) has written a well-researched and gripping overview of posttraumatic growth. His book is scientifically grounded and filled with engaging examples.

Posttraumatic growth research that focuses on children who have been abused sexually, physically, and/or psychologically is socially and culturally tricky. Some even say that this research aids and abets trauma. But we can take Stephen Joseph’s (2009) advice to heart:

Therapists should be aware of the potential for positive change in their clients following adversity. But, importantly, we need to be careful not to inadvertently imply that there is anything inherently positive in trauma. . . . Tedeschi and Calhoun (2004) make it clear that personal growth after trauma should be viewed as originating not from the event, but from within the person themselves through the process of their struggle with the event and its aftermath. (p. 341)

So some clients have the ability to seize the horror of abuse or torture or almost any kind of disorder and somehow use it as a stimulus for growth. We can be glad that there is such a thing as posttraumatic growth and that we can help clients in their struggle to benefit from it.

## Help Clients Get Along without a Helper LO 8.6

We have known people who have remained “in therapy” for years, but we do not—or perhaps do not want to—understand why. We do understand the following possible approaches to therapy by clients:

- The counselor helps clients with their plans for constructive change and then clients, using their own initiative and resources, take responsibility for the plans and pursue them on their own.
- Clients continue to see a helper regularly in the implementation phase until the desired changes are “in place.” Then they keep them in place by using their own internal and external resources.
- Clients, after spending some time with a helper, join some kind of self-help group to get the kind of support they need to continue a change program successfully. This may be complemented by an occasional one-to-one session with the helper.
- Clients continue to see a helper occasionally, as the need arises.
- Some clients, with debilitating psychological conditions such as bipolar or addiction disorders, find it necessary to tap into therapy throughout their lives.

In the end, however, most clients need to get on with their lives without a helper. Part of the shadow side of helping is the fact that some helpers enter into an unintentional conspiracy with their clients to maintain the relationship. In effect, talking takes the place of action leading to life-enhancing outcomes. In such cases the co-dependent helping relationship becomes the problem rather than the solution.

## Remember that Some Clients Choose Not to Change **LO 8.7**

Some clients who seem to do well in analyzing problems, developing goals, and even identifying reasonable strategies and plans end up by saying—in effect, if not directly—something like this: “Even though I’ve explored my problems and understand why things are going wrong—that is, I understand myself and my behavior better, and I realize what I need to do to change—right now I don’t want to pay the price called for by action. The price of more effective living is too high.”

The question of human motivation seems almost as enigmatic now as it must have been at the dawning of the history of the human race. So often we seem to choose our own misery. Worse, we choose to stew in it rather than endure the relatively short-lived pain of behavioral change. Helpers can and should invite clients to challenge themselves to search for incentives and rewards for managing their lives more effectively. They should also help clients understand the consequences of not changing. But in the end, it is the client’s choice.

Box 8.2 summarizes some of the main principles to be followed in helping clients manage change in their lives.

### **BOX 8.2**

#### **Action-Arrow Guidelines for Helping Clients to Move Forward**

Here are some guidelines for helping clients develop a bias for problem-managing and opportunity-developing action as they strive to develop goals and implement plans.

- Understand how widespread both inertia and entropy are and how they are affecting this client.
- Help clients become effective tacticians.
- Help clients form “implementation intentions” especially when obstacles to goal attainment are foreseen.
- Help clients avoid both procrastination and imprudent action.
- Help clients develop contingency plans.
- Help clients discover and manage obstacles to action.
- Help clients discover resources that will enable them to begin acting, to persist, and to accomplish their goals.
- Help clients find the incentives and the rewards they need to persevere in action.
- Help clients acquire the skills they need to act and to sustain goal-accomplishing action.
- Help clients develop a social support and challenge system in their day-to-day lives.
- Prepare clients to get along without a helper.
- Come to grips with the fact that helpers need to become agents of change in their own lives.
- Face up to the fact that not every client wants to change.

# The Three Tasks of Stage I: Help Clients Tell the Story, the Real Story, and the Right Story

## LEARNING OBJECTIVES

### 9.1 Prepare Yourself for Doing the Work of Stages I, II, and III

Review the Graphic of Stage I and Understand What Is Meant by the Term Task  
Explore the Challenges Clients Face in Talking about Themselves  
Review the Case That Will Be Used to Illustrate Stage I

### 9.2 I-A: Learn Ways of Helping Clients Tell Their Stories

Help the Client Feel Safe in the Helping Encounter  
Learn to Work with All Styles of Storytelling  
Start Where the Client Starts  
Assess the Severity of the Client's Problems  
Help Clients Identify and Clarify Key Issues  
Help Clients Explore the Context of Their Concerns  
Help Clients Talk Productively about the Past  
Right from the Beginning, Help Clients Spot Unused Opportunities  
Help Clients See Every Problem as an Opportunity  
As Clients Tell Their Stories, Help Them Search for Unused Resources

### 9.3 I-B: Use Self-Challenge to Help Clients Tell the Real Story

Determine the Real Story in the Case of Alisa  
Help Clients Challenge the Quality of Their Participation  
Consider the Wider Use of Self-Challenge

### 9.4 I-C: Help Clients Focus on the Right Story

Return to the Alisa-Rena Case  
Apply the Principles for Helping Clients Choose Issues That Will Make a Difference in Their Lives  
Use Self-Challenge to Help Clients Make the Right Decisions

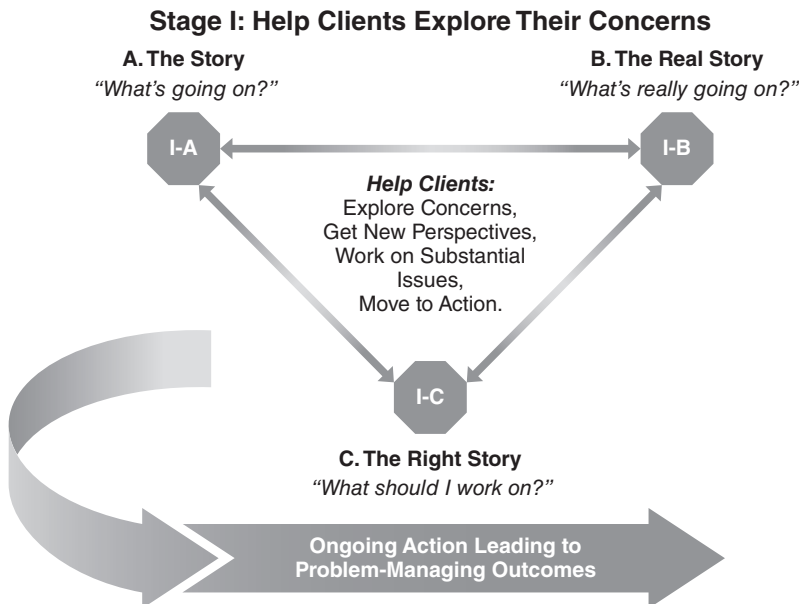
### 9.5 Start Early with Links to Action

## Prepare Yourself for Doing the Work of Stages I, II, and III LO 9.1

Do four things before exploring and devouring the helping framework as outlined and illustrated in Chapters 9–11. First, reread Chapter 2 to give yourself an overview of the helping process. This will help avoid unneeded repetition. Second, see the stages and the tasks within the stages, not as linear steps, but as ways of helping clients move forward as they grapple with problem situations and unused opportunities. Third, take to heart the lessons of Chapter 8 so that you can clearly see the stages and the tasks within the stages as stimuli for client action. Fourth, come to the realization that to do all this you need to be competent in all the communication skills outlined and illustrated in Chapters 4–7. Conversations with clients should be the kind of dialogues outlined and illustrated in Part II of this book.

### Review the Graphic of Stage I and Understand What Is Meant by the Term Task

Stage I illustrates three interrelated ways in which counselors can help clients understand themselves, their problem situations, and their unused opportunities with a view to managing them more effectively. Counselors help clients (A) tell their stories, (B) reframe their stories, develop new, more useful perspectives, and begin thinking about new, more constructive ways of acting, and (C) stay focused on the key issues and concerns that will make a difference in their lives. These three tasks are illustrated in Figure 9.1.



**FIGURE 9.1**  
The Tasks of Stage I

Even though these tasks are described separately, in actual helping sessions, as described in Chapter 2, they are intermingled. The two-headed arrows in Figure 9.1 highlight the fact that it is not a question of moving from the first to the second to the third task in any rigid way. Stay focused on the needs of clients.

### Explore the Challenges Clients Face in Talking about Themselves

Denise Sloan (2010) reviews the evidence that links self-disclosure in various settings including psychotherapy, to psychological well-being. People in general tend to want to talk about themselves when things are good and when things are bad. She goes on to say, “In addition to facilitating social bonds, self-disclosure also produces a wide variety of health benefits” (p. 212).

The importance of helping clients tell their stories well should not be underestimated. As Pennebaker (1995b) has noted, “An important . . . feature of therapy is that it allows individuals to translate their experiences into words. The disclosure process itself, then, may be as important as any feedback the client receives from the therapist” (p. 3). Much has been written about clients’ reluctance to talk about themselves, but Farber, Berano, and Capobianco (2004) outline the bright side of client self-disclosure.

Most clients feel that therapy is a safe place to disclose, made especially so by the goodness of the therapeutic relationship; that the disclosure process initially generates shame and anticipatory anxiety but ultimately engenders feelings of safety, pride, and authenticity; that keeping secrets inhibits the work of therapy, whereas disclosing produces a sense of relief from physical as well as emotional tension; that disclosures in therapy facilitate subsequent disclosures to one’s therapist as well as to family members and friends; and that therapists should actively pursue material that is difficult to disclose. (p. 340)

Of course, other research has shown that fear of self-disclosure is a leading factor in not seeking therapy (Vogel & Wester, 2005). So it is important for you to discern whether the client you are helping is eager to engage in self-disclosure or fears it. Like most of us, clients have secrets, some of which they have told to no one (Slepian, Chun, & Mason, 2017). Some of these may be related to the problem situations clients are discussing. Empathy and tact are needed to help them talk about secrets that may be haunting them. Farber and his associates (Farber, Berano, & Capobianco, 2004) note that many clients welcome and appreciate counselors’ efforts to help them discuss painful issues. See Farber’s (2006) book *Self-Disclosure in Psychotherapy* for a comprehensive overview of both client and helper self-disclosure.

Stage I of the helping process can be seen as the assessment stage (Hays, 2013)—finding out what’s going wrong, what opportunities remain undeveloped, what resources are not being used. **Client-centered assessment** means helping clients understand themselves, find out “what’s going on” with their lives, see what they have been ignoring, and make sense from the messiness of their lives. Assessment in this sense is not something helpers do to clients. Rather, it is a kind of practical learning in which both client and helper collaborate. Other forms of assessment such as psychological testing and applying psychiatric diagnostic categories may or may not be useful, but they are beyond the scope of this book.

## Review the Case That Will Be Used to Illustrate Stage I

Here is the case of Alisa and her therapist Rena. We will refer to it in describing the three tasks of Stage I.

Alisa, a biracial (Latina and White) 28-year-old woman, is meeting the first time with a behavioral health professional, Rena, after being referred by her primary care physician. She went to her lifetime family doctor for help with her persistent headaches and problems with sleeping. Alisa has been to Dr. Cooper's office multiple times over the last few months with a variety of physical concerns. More recently, her live-in boyfriend left her saying he "felt overwhelmed" by her and "couldn't breathe." He is one of several failed relationships that were typically intense, but short-lived. She has had few good female-male relationships in her life. Her Facebook and Instagram relationships lack substance. Social media interactions, though constant, seem to be nothing more than an escape from long-term unhappiness. She has worked in an accounting office for six years and essentially does the work of a CPA though for much less pay. She dropped out of college after her sophomore year because she ran out of money and felt overwhelmed trying to work and tend to her academics. Alisa was the first in her family to go to college and comes from a rural background and a traditional, conservative family with two older sisters and a younger brother. One sister and her brother work at the local car plant. Her other sister has three children and works in the home. They all live in the same community. Alisa longs for more out of life but is confused about what "more" means. And, when it comes to family, she feels that the term "black sheep" fits.

Alisa had high scores on a general distress screener that led to a "warm handoff" after the physician consulted with Rena Phelps, the staff behavioral health professional (BHP). Rena is a 41-year-old, Latina psychologist who works in a rural healthcare facility that uses an integrated care approach. She worked in a community mental healthcare agency for several years but was asked to join the family practice along with a social worker, nutritionist, and two nurse practitioners. She consults with the other team members as needed and will do intakes with patients when referred by the physician or nurse practitioners (called a "warm hand off") to further determine the needs of the patient. If the patient and Rena collaboratively decide that counseling is needed, Rena can see the patient for brief therapy (up to eight sessions). Using the communication skills outlined in Part II, she helps Alisa tell her story and review her concerns.

Rena, wearing a white coat over her casual dress of jeans and loafers, walks in to the exam room where Alisa is waiting. She extends her hand, saying, "Hi Alisa, I am Dr. Phelps, a behavioral health specialist. Please call me Rena. It's nice to meet you. Did Dr. Sampson explain why we are meeting?" Alisa responds that she did. Rena points to two chairs, adjusts them so they face each other and says, "How about we both sit down here so we can better talk." After they sit down, Rena warmly says, "Dr. Sampson shared a little about what is going on with you, but I would like to hear what is going on from your point of view and we can see if and how I can help." Alisa immediately becomes tearful and says, "I feel like my world has come to end and I just do not know what to do. My boyfriend moved out, I am now stuck with a townhouse I can't afford, and that is just the start. I can go on and on. My job is crummy, I hardly have any friends, and to top it all off (she exhales and gulps) my family barely speaks to me." She cries. Waiting a moment to make sure she is finished, Rena says, "That is quite a lot. So maybe together we can sort through some of these things and make sense of them? Does that sound okay?" Alisa, head down, nods. She collects herself and notes she has tried therapy before and said it



“helped some but I quit before I should have.” Rena says they can talk about what was helpful before in counseling.

Before beginning the helping dialogue, Rena administers a risk- assessment survey. Although beyond the scope of our book, risk-assessment tools provide a sometimes necessary overview of the current state of the client with respect to self-harm and possible harm to others (Cormier, Nurius, & Osborn, 2016). Rena asks straightforward questions, but with warmth and concern, that is, she does not set aside her usual interpersonal style just because she is doing a risk assessment. The results show that that it is most likely that Alisa poses no harm to herself or others.

This is a complicated case and counseling is not a magic process that can easily resolve it. Rena has in mind the broad goals or outcomes described in Chapter 1: help Alisa manage key problem areas and help her learn some basic ways of helping herself. The case is not presented as a neat package. Rather we note some of the things Rena did to help Alisa. They are designed to make you think what you might do if you were Alisa’s helper. Different helpers will take different approaches. See yourself as Alisa’s therapist. Keep answering the question: What would I do to help Alisa at this point? Be entrepreneurial. Do not be afraid to make decisions different from those found in the text.

## Task A: Learn Ways of Helping Clients Tell Their Stories LO 9.2

These guidelines are not hard and fast rules. Some of the guidelines and examples here and in subsequent chapters include the kind of “nudging” and invitations to self-challenge discussed in Chapters 6 and 7. Helpers have to make a judgment about invitations to self-challenge based, not on their theories, but on the needs of clients. Clients’ needs take precedence over helping models.

That said, there are a number of principles that can guide you as you help clients tell their stories. Hanna (2002) has developed a list of “precursors,” which “taken together form a comprehensive picture of how people change and why they do not” (p. 6). This is Hanna’s version of the readiness-for-change list outlined in Chapter 2. His “precursors” include, on the part of the client, a sense of necessity (“I’ve got to do something about this”), a willingness to experience anxiety or difficulty, awareness of the main factors in the problem situation, a desire to confront the problem, effort directed toward change, hope for a better future, and social support. Hanna calls these conditions “regulators of change” in the sense that “the more they are present in a person, the more quickly change will occur, and in some cases, the deeper the change will be in the psyche of the person” (p. 6). As clients tell their stories, you can listen and probe for these regulators and even help clients develop them. Here, then, is a basic set of guidelines. Ultimately, as an artist or entrepreneur, you will develop your own set.

### Help the Client Feel Safe in the Helping Encounter

Many of your clients will feel anxious as they arrive. While a reasonable amount of anxiety is actually helpful because it serves as a motivator, too much is counterproductive. It gets in the way of the work to be done. Rena’s first task is to help Alisa tell her story. Here’s how she begins. First, she makes sure that they are

facing each other so that Alisa could have her full attention (SOLER in Chapter 4). Second, she approaches Alisa in a collaborative manner—she uses the words like “we” and “together” and checks in with her to ask what she thinks “does that sound okay?” Third, she uses basic communication skills, especially empathy, to move the conversation forward. Fourth, she does what she can to keep Alisa in the driver’s seat. The sooner Alisa realizes that helping is about doing rather than just talking the better. So right from the beginning Rena looks for things that Alisa can do to move forward.

Alisa quickly opens up to Rena, but there is a note of hesitancy in her voice. Rena understands this, especially because the whole process began with a risk-assessment survey. Alisa needs to become comfortable with Rena and the whole process. She explains the problem-management and opportunity-development process to Alisa. But she will continue to explain the “geography” of helping as needed throughout the process. She will take her cues from her client in order to translate science into art.

### **Learn How to Work with All Styles of Storytelling**

There are both individual and cultural differences in clients’ willingness to talk about themselves. Both affect storytelling. Some clients are highly verbal and quite willing to reveal almost everything about themselves at the first sitting. Take the case of Martina.

Martina, 27, asks a counselor in private practice for an appointment to discuss “a number of issues.” Martina is both verbal and willing to talk. Her story comes tumbling out in rich detail. Although the helper uses the skills of attending, listening, sharing highlights, and probing, she does so sparingly. Martina is too eager to tell her story.

Although trained as a nurse, Martina is currently working in her uncle’s business because of an offer she “could not turn down.” She is doing very well financially, but she feels guilty because service to others has always been a value for her. And although she likes her current job, she also feels hemmed in by it. A year of study in Europe during college whetted her appetite for “adventure.” She feels that she is nowhere near fulfilling the great expectations she has for herself. She feels that she is denying the “entrepreneur” inside her.

She also talks about her problems with her family. Her father is dead. She has never gotten along well with her mother, and now that she has moved out of the house, she feels that she has abandoned her younger brother, who is 12 years younger than she is and whom she loves very much. She is afraid that her mother will “smother” her brother with too much maternal care.

Martina is also concerned about her relationship with a man who is 2 years younger than she. They have been involved with each other for about 3 years. He wants to get married, but she feels that she is not ready. She still has “too many things to do” and would like to keep the arrangement they have.

This whole complex story—or at least a synopsis of it—comes tumbling out in a torrent of words. Martina feels free to skip from one topic to another. The way Martina tells her story is part of her enthusiastic style. At one point she stops, smiles, and says, “My, that’s quite a bit, isn’t it!”

As the helper listens to Martina, he learns a number of things about her. She is young, bright, and verbal and has many resources; she is eager and impatient;

some of her problems are probably of her own making; she has some blind spots that could stand in the way of her grappling more creatively with her problems; and she has many unexplored options and many unexploited opportunities. That said, the counselor surmises that Martina would probably make her way in life, however erratically, with no counseling at all.

Contrast that example with the following one of a man who comes to a local mental health center because he feels he can no longer handle his 9-year-old boy.

Nick is referred to the center by a doctor in a local clinic because of the trouble he is having with his son. He has been divorced for about two years and is living in a housing project on public assistance. After introductions and preliminary formalities have been taken care of, he just sits there and says nothing; he does not even look up. Because Nick offers almost nothing spontaneously, the counselor uses a relatively large number of probes to help him tell his story. Even when the counselor responds with empathy, Nick volunteers very little. Every once in a while, tears well up in his eyes. When asked about the divorce, he says he does not want to talk about it. “Good riddance” is all he can say about his former wife. Gradually, almost torturously, **the story** gets pieced together. Nick talks mostly about the “trouble” his son is getting into, how uncontrollable he seems to be getting, and how helpless he [Nick] feels.

Martina’s story is full of possibilities, whereas Nick’s is mainly about limitations. In both content and communication style, they are at opposite ends of the scale. Alisa’s style is somewhere in the middle.

Each client is different and will approach the telling of the story in a different way. Some clients will come voluntarily; others will be sent. Some of the stories you will help clients tell will be long and detailed, others short and stark. Some will be filled with emotion; others will be told coldly, even though they are stories of terror. Some stories will be, at least at first blush, single-issue stories—“I want to get rid of these headaches”—whereas others, like Alisa’s and Martina’s, will be multiple-issue stories. Some stories will deal with the inner world of the client almost exclusively—“I hate myself,” “I’m depressed,” “I feel lonely”—whereas others will deal with the outer world, for instance, problems with finances, work, or relationships. Still others will deal with a combination of inner and outer concerns.

Some clients will tell the core story immediately, whereas others will tell a secondary story first to test your reactions. Some clients will make it clear that they trust you just because you are a helper, but you will read mistrust in the eyes of others, sometimes just because you are a helper. In all these cases, your job is to establish a working relationship with your clients and help them tell their stories as a prelude to helping them manage the problems and take advantage of the opportunities buried in those stories. A story that is brought out into the open is the starting point for possible constructive change. Often the very airing of the story is a solid first step toward a better life.

When clients like Martina pour out their stories all at once, you may let them go on or you may insist on some kind of dialogue. If the client tells the “whole” story in a more or less nonstop fashion, it will be impossible for you to share highlights relating to every core issue the client has brought up. But you can then help the client review the most salient points in some orderly way. For example, you might

want to help the client review the core parts of the story by saying something like this: “You’ve said quite a bit. Let’s see if I’ve understood some of the main points you’ve made. First of all. . . .” At this point the highlights you share will let the client know that you have been listening intently and that you are concerned about him or her. With clients like Nick, however, it’s a different story. Those who lack the skills needed to tell their stories well or who are reluctant to do so constitute a different kind of challenge. Engaging in dialogue with them can be hard work.

Alisa’s style could be described as free flowing. She moves quickly from topic to topic, gives a torrent of detail mixed with strong emotion, stops in the middle of things especially when her emotions get the best of her, becomes silent in the middle of a thought, asks unrelated questions, frequently apologizes for herself—all in all a rather chaotic style. Rena listens carefully, uses the helping framework to put the chaos into some kind of order for herself, responds to what she sees as key issues with empathy, occasionally asks brief questions to help bring more order to the chaos, and does her best to turn the torrent into some kind of dialogue. Alisa calms down in later sessions and, with Rena’s help, finds her own kind of order in the chaos.

### Start Where the Client Starts

Clients often do not start with the logic of the helping process, Stage I Task A. Clients’ starting points are expressions of their needs. They can start with any stage of the helping process. Join them there. Therefore “story” is used in its widest sense. It does not mean, narrowly, “This is what happened to me, here’s how I reacted, and now this is how I feel.” Your job is to stay with your clients no matter where they are, not where you would like them to be. Use the Stage-I framework in Figure 9-1 as a map. Know where the client is in this “geography” so that you can help them think about where they need to go. Here is a range of clients, each starting at a different point in the helping process.

- **Stage I: What’s Going on?** Eric begins by saying, “The last time I was in therapy, I was in a real mess. I’m still in a mess. I was addicted to painkillers and trying to stop on my own. I was belligerent at work. They called me a ‘difficult’ employee. But the managers were really stupid. I had just lost a girlfriend. But maybe that was for the best. She certainly had her problems. Not that I didn’t. The match was wrong. I’m back here because I’ve just been fired. I tackled the pill problem. I do not take any of that stuff now. I’m clean and it wasn’t easy. I was sure that would help me straighten things out.” Eric worked on a problem, even successfully, but it wasn’t the key problem. He probably would have done better to realize that he had a problem relating to people. You can help him start over.
- **Stage II: What Do I Want?** Thad says, “I do not know whether I want to be a doctor or a politician—or at least a political scientist. I love both, but I can’t do both. I mean I have to make my mind up this coming year and choose my college courses. I hate being stuck with this kind of decision.” Thad’s starting point is choosing a goal. He has an approach-approach conflict. He wants both goals. You can help him weigh the pros and cons of each option.
- **Stage III: How Can I Get What I Want?** Kimberley, a human resources executive for a large bank, says, “I’ve found out that our bank president has been involved in some unethical and, I think, immoral behavior.

He's due to retire within the next 6 months. I do not know whether it's best to bring all this to light or just monitor him till he goes. If I move on him, this could blow up into something big and hurt the reputation of the bank itself. If I just monitor him till he goes, he gets away with it and our clients may get hurt. I want to do what's best for the company and our clients." Her starting point is a dilemma about which *action strategy* to use. You can help Kimberley search for the strategy that best-fits the needs of the institution and its clients.

- **The Action Arrow.** Owen is having problems sticking to his resolve to restrain himself when one of his neighbors on his block "does something stupid." He says, "I know when I speak up [his euphemism for flying off the handle] things tend to get worse. I know I should leave it to others who are more tactful than I am. But they do not move quickly enough—or forcefully enough." His starting point is *difficulty in implementing a course of action* to which he has committed himself. You can help Owen find incentives for sticking to his program.
- **A Failed Solution.** Martha starts by saying, "I thought I knew how to handle my son when he reached his teenage years. I knew he might want to try all sorts of crazy things, so I might have to keep the reins pretty tight. And that's what I did. But now things are awful. It's not working. He's out of control. The more I've tried to control him the worse he's got. I do not know what I've done wrong." Martha has gone all the way through the helping process but has come up empty-handed. Martha's starting point is a *failed solution*, which has spawned a new problem. You can help Martha take another look at her son's behavior and come up with solutions that fit his and her needs.

Alisa starts with a mixture of all these in no particular order. There are a number of themes: her trouble with men, her lack of purpose in life, her feeling alienated from her family, her lack of educational credentials, and her dissatisfaction with being a contract worker instead of being a "real" employee. In the beginning it is not clear what is most important for her.

### Assess the Severity of the Client's Problems

Clients come to helpers with problems of every degree of severity. Objectively, problems run from the inconsequential to the life-threatening. Subjectively, however, a client can experience even a relatively inconsequential problem as severe. If a client thinks that a problem is critical, even though by objective standards the problem does not seem to be that bad, then for him or her it is critical. In such a case, the client's tendency to "catastrophize"—to judge a problem situation to be more severe than it actually is—itself becomes an important part of the problem situation. One of the counselor's tasks in this case will be to help the client put the problem in perspective or to teach him or her how to distinguish between degrees of problem severity. Howard (1991, p. 194) puts it well:

In the course of telling the story of his or her problem, the client provides the therapist with a rough idea of his or her orientation toward life, his or her plans, goals, ambitions, and some idea of the events and pressures surrounding the particular presenting problem. Over time, the therapist must decide whether this problem

represents a minor deviation from an otherwise healthy life story. Is this a normal, developmentally appropriate adjustment issue? Or does the therapist detect signs of more thorough-going problems in the client's life story? Will therapy play a minor, supportive role to an individual experiencing a low point in his or her life course? If so, the orientation and major themes of the life will be largely unchanged in the therapy experience. But if the trajectory of the life story is problematic in some fundamental way, then more serious, long-term story repair might be indicated. So, from this perspective, part of the work between client and therapist can be seen as life-story elaboration, adjustment, or repair.

Savvy therapists not only gain an understanding of the severity of a client's problem or the extent of the client's unused resources, but also understand the limits of helping. What has been this client's highest lifetime level of functioning? What, then, are appropriate expectations? What Howard calls life-story adjustment or repair is not the same as attempting to help clients redo their personalities.

Years ago Mehrabian and Reed (1969) suggested the following formula as a way of determining the severity of any given problem situation. Even though it is not a mathematical formula, it is still useful today.

$$\text{Severity} = \text{Distress} \times \text{Uncontrollability} \times \text{Frequency}$$

The multiplication signs in the formula indicate that these factors are not just additive. Even low-level anxiety, if it is uncontrollable or persistent, can constitute a severe problem; that is, it can severely interfere with the quality of a client's life. In some cases, assessing for possible self-harm or harm to others is called for. The literature on suicide details possible self-harm signs that you need to look out for. You can also review the literature on violence in social relationships for signs of possible impending aggression. Even a casual reading of accounts of outbreaks of social violence such as fired employees gunning down superiors and colleagues tells us how easily signs can be missed. Of course, assessment is not a one-time thing but rather it is always a part in your role as a helper to best understand the client's situation and needs.

The use of brief screening instruments as illustrated earlier with Alisa can be a helpful way to assess a client's level of distress. This could be done as part of a formalized feedback system to monitor treatment progress. This offers a means to literally "get on the same page" with your client and offer a touchstone for both client and helper to know if treatment is helping and progress is being made. For example, after Alisa agreed to continue meeting with Rena, she completed the same general distress assessment survey again. The scores had gone down some. When Rena brought up Alisa's lower scores (indicating less distress), Alisa said, "Just being able to talk about everything bouncing around in my head helped me to organize things. It gave me some perspective. You were so positive; I guess I . . . just felt some hope knowing I was coming back to work on my stuff. I have not felt much hope lately."

## Help Clients Identify and Clarify Key Issues

To clarify means to discuss problem situations and unused opportunities—including possibilities for the future, goals, and strategies for accomplishing goals,



plans, implementation issues, and feelings about all of these—as concretely as possible. Vagueness and ambiguity lead nowhere. Clarity means helping clients move from the general to the specific—specific experiences, thoughts, behaviors intentions, points of view, and decisions. If client has poor communication skills, use your skills to help them engage in the dialogue.

Consider this case. Nina's husband has been suffering from severe depression for over a year. One day, after Nina suffers a fainting spell, she, too, talks with a counselor. At first, feeling guilty about her husband, she is hesitant to discuss her own concerns. In the beginning she says only that her social life is “a bit restricted by my husband's illness.” With the help of empathic highlights and probing on the part of the helper, her story emerges. “A bit restricted” turns, bit by bit, into the following, much fuller story. What follows is a summary. Nina did not say this all at once.

John has some sort of “general fatigue syndrome” illness that no one has been able to figure out. It's like nothing I've ever seen before. I move from guilt to anger to indifference to hope to despair. I have no social life. Friends avoid us because it is so difficult being with John. I feel I shouldn't leave him, so I stay at home. He's always tired, so we have little interaction. I feel like a prisoner in my own home. Then I think of the burden he's carrying and the roller-coaster emotions start all over again. Sometimes I can't sleep and then I'm as tired as he is. He is always saying how hopeless things are and, even though I'm not experiencing what he is, some kind of hopelessness creeps into my bones. I feel that a stronger woman, a more selfless woman, a smarter woman would find ways to deal with all of this. But I end up feeling that I'm not dealing with it at all. From day to day I think I cover most of this up, so that neither John nor the few people who come around see what I'm going through. I'm as alone as he is.

This is the fuller story spelled out in terms of specific experiences, thoughts, behaviors, and feelings. The actions Nina takes—staying at home, covering her feelings up—are part of the problem, not the solution. But now that the story is out in the open, there is some possibility of doing something about it.

In another case, a woman suffering from bulimia is now under psychiatric care, says that she acted “a little erratically at times” with some of her classmates in law school. The counselor, sharing highlights and using probes, helps her tell her story in much greater detail. Like Nina, she does not say all of this at once, but this is the fuller picture of “a little erratic.”

I usually think about myself as plain looking, even though when I take care of myself some say that I do not look that bad. Ever since I was a teenager, I've preferred to go it alone, because it was safer. No fuss, no muss, and especially no rejection. In law school, right from the beginning I entertained romantic fantasies about some of my classmates who I didn't think would give me a second look. I pretended to have meals with those who attracted me and then I'd have fantasies of having sex with them. Then I'd purge, getting rid of the fat I got from eating and getting rid of the guilt. But all of this didn't just stay in my head. I'd go out of my way to run into my latest imagined partner in school. And then I'd be rude to him to “get back at him” for what he did to me. That was my way of getting rid of him.

She was not really delusional, but gradually her external behavior with a kind of twisted logic began to reinforce her internal fantasies. However, once her



story became “public”—that is, once she began talking about it openly with her helper—she began to take back control of her life.

Alisa tends to talk emotionally about many issues, such as personal relationships, family, and job, but expressing emotion is not the same as providing clarity. Rena’s job is to help her talk about such things as intentions and behaviors. For instance she talks about feeling alienated from her family. The question is: “What’s going on here?” Using empathy, probing, and other forms of “nudging,” Rena helps Alisa talk about changes in her personal culture. Two years at college opened her to ways of thinking and behaving that were foreign to her family’s conservative values. “Living with my boyfriend drove them crazy.” You can imagine the impact of a series of boyfriends, live-in or not. A primary lesson: choices have consequences.

### Help Clients Explore the Context of Their Concerns

Helping clients explore the background or context of their concern can add a great deal of clarity. Without context, be it cultural, environmental, situational, or some combination, understanding of any story is incomplete and potentially inaccurate. Kenneth Noland, famous painter, is credited with saying “For me context is the key—from that comes the understanding of everything.” Consider the following case.

In a management development seminar, Tarik tells his counselor that he is a manager in a consulting firm. The firm is global, and he works in one of its offices in Southeast Asia. He says that he is already overworked, but now his new boss wants him to serve on a number of committees that will demand even more of his precious time. He is also having trouble with one of his subordinates, himself a manager, who Tarik says is undermining his authority in the wider team.

So far we have a garden-variety story, one that could be repeated thousands of time throughout the world. The counselor, however, suspects there is more to this. Because the counselor is Canadian, he wants to learn about Tarik’s Middle Eastern culture to get the full picture. He knows that there is an overlay of Western culture in these consulting firms, but he wants to deal with his client as a full person. And so in sharing highlights and by using a few probes, he learns enough about the background of the manager’s story to cast a new light on the problem situation. Here is the fuller story that emerges.

Tarik is not only a manager in the firm, but also a partner. However, he is a newly minted partner. The organizational structure in these firms is relatively flat, but the culture is quite hierarchical. And so the clients he has been given to work with are, in large part, the “dogs” of the region. His boss is an American who has been in his present job for only 4 months. Tarik has heard through the grapevine that he [his boss] is going to stay for only 1 more year. Because the boss is near retirement, this is his “fling” in Asia. Though a decent man, he is quite distant and offers Tarik little help. This leads Tarik to believe that his real boss is his boss’s boss, whom he can’t approach because of company and cultural protocol. The subordinate who is giving Tarik trouble is also a partner. In fact, he has been a partner for several years, but has not been very successful. This man thought that he should have been made the manager of the unit Tarik is now running. He has been engaging in a bit of sabotage behind Tarik’s back.

A search for some background quickly takes the client's story out of the "routine" category. Of course, you should not be looking for background just for the sake of looking. The right kind and amount of background provides both richness and context.

As to Alisa's job, business context is critical. Contract employment might be all right if you lived in a big city with lots of opportunities, but not in a small town. But Alisa's employer has offices countrywide. She thought that driving for Uber was a bearable contract job but assumed that contract employment had no place in the professions such as accounting.

### **Help Clients Talk Productively about the Past**

Some schools of psychology suggest that problem situations are not clear and fully comprehended until they are understood in the context of their historic roots. Therefore helpers in these schools spend a great deal of time helping clients uncover the past. However, if both the client and the helper are on "the same page" in this regard, therapy can be successful. Others disagree with that point of view. Glasser (2000, p. 23) puts it this way: "Although many of us have been traumatized in the past, we are not the victims of our past unless we presently choose to be. The solution to our problem is rarely found in explorations of the past unless the focus is on past successes."

As you can imagine, this is an issue that members of the helping professions argue about endlessly. We do not wish to wade into these waters. Here are some suggestions for helping clients talk meaningfully and productively about the past.

***Help clients talk about the past to make sense of the present*** Many clients come expecting to talk about the past or wanting to talk about the past. There are ways of talking about the past that help clients make sense of the present. But making sense of the present needs to remain center stage. Thus, how the past is discussed is more important than whether it is discussed. The following man has been discussing how his interpersonal style gets him into trouble. His father, now dead, played a key role in the development of his son's style.

**HELPER:** So your father's unproductive interpersonal style is, in some ways, alive and well in you.

**CLIENT:** Until we began talking I had no idea about how alive and well it is. For instance, even though I hated his cruelty, it lives on in me in much smaller ways. He beat my brother. But now I just cut him down to size verbally. He told my mother what she could do and couldn't do. I try to get my mother to adopt my "reasonable" proposals "for her own good"—without, of course, listening very carefully to her point of view. There's a whole pattern that I haven't noticed. I've inherited more than his genes.

**HELPER:** That's quite an inheritance. . . . But now what?

**CLIENT:** Well, now that I see what's happened, I'd like to change things. A lot of this is ingrained in me, but I do not think it's genetic in any scientific sense. I've developed a lot of bad habits.

This client's understanding of his connection with the past may well prove helpful. While his father has influenced him, influence is not destiny. He is responsible for his behavior, not his father. The problem has been named. It is about "bad habits" whatever their origin, not sociobiological determinism.

***Help clients talk about the past to be reconciled to or liberated from it***

A potentially dangerous logic can underlie discussions of the past. It goes something like this: "I am what I am today because of my past. But I cannot change my past. So how can I be expected to change today?"

**CLIENT:** I was all right until I was about 13. I began to dislike myself as a teenager. I hated all the changes—the awkwardness, the different emotions, having to be as "cool" as my friends. I was so impressionable. I began to think that life actually must get worse and worse instead of better and better. I just got locked into that way of thinking. That's the same mess I'm in today.

That is not liberation talk. The past is still casting its spell. Helpers need to understand that clients may see themselves as prisoners of their past, but with empathy we must help them challenge themselves to move beyond such self-defeating beliefs.

The following case provides a different perspective. It is about the father of a boy who has been sexually abused by a minister of their church. He finds that he can't deal with his son's ordeal without revealing his own abuse by his father. In a tearful session he tells the whole story. In a second interview he has this to say:

**CLIENT:** Someone said that good things can come from evil things. What happened to my son was evil. But we'll give him all the support he needs to get through this. Though I had the same thing happen to me, I kept it all in until now. It was all locked up inside. I was so ashamed, and my shame became part of me. When I let it all out last week, it was like throwing off a dirty cloak that I'd been wearing for years. Getting it out was so painful, but now I feel so different, so good. I wonder why I had to hold it in for so long.

This is liberation talk. When counselors help or encourage clients to talk about the past, they should have a clear idea of what their objective is. Is it to learn from the past? Is it to be liberated from it? To assume that there is some "silver bullet" in the past that will solve today's problem is probably asking too much of the past.

King and Hicks (2007) have shown that discussing lost opportunities and mistaken expectations and the regrets, disappointments, and humiliation associated with them can prove quite beneficial. Facing up to failures has its unpleasant side, but, as these authors note, "If contentment were the sole goal of adulthood, examining life's regrettable experiences might seem to have little value" (p. 625). Their research shows that it is possible to learn and grow by reviewing what might have been. "Recognition of the losses that have led to one's current place in the life story may open one up to a number of valuable and rich experiences, including a paradoxical sense of gratitude for loss itself" (p. 634).

***Help clients talk about the past in order to prepare for action in the future***

The well-known historian A. J. Toynbee had this to say about history: “History not used is nothing, for all intellectual life is action, like practical life, and if you do not use the stuff—well, it might as well be dead.” As we will soon see, any discussion of problems or opportunities should lead to constructive action, starting with Stage I and going all the way through to implementation. The insights you help clients get from the past should in some way stir them to action. When one client, Christopher, realized how much his father and one of his high school teachers had done to make him feel inadequate, he made this resolve: “I’m not going to do anything to demean anyone around me. You know, up to now I think I have, but I called it something else—wit. I thought I was being funny when I was actually being mean.” Help clients invest the past proactively in the future.

The guidelines relating to talking about the past are not set in stone. They do not imply that you should never let clients talk about the past unless they do it in a way that fits the guidelines reviewed here. Short (2006) puts it well: “I do not like to focus on the past or on a person’s symptoms, but people shouldn’t suffer alone, so I listen to these stories with respect and acceptance” (p. 72). To do otherwise would contribute to what Hansen (2005) calls the “devaluation of [clients’] inner subjective experiences by the counseling profession” (p. 83). Furthermore, as mentioned earlier, some approaches to helping include deeper searches into a client’s past as an essential part of their approach. Remember what was said about the treatment method in Chapter 1. In the hands of helpers who are competent in orchestrating the key ingredients of successful therapy, any solid approach to treatment can be useful.

For the most part, Alisa did not talk about the past. Her major concerns were beating down on her almost every day. She did talk about what family life “used to be.” She had loved family life. She had changed a lot, but her family had not. She tended to blame her family for not changing. Rena tried to help her review the current cultural differences between her and her family and to find creative ways of reconciling them.

**Right from the Beginning, Help Clients Spot Unused Opportunities**

Note that Martina’s story is about both problem situations and opportunities. Many stories are a mixture of both. Early in the history of modern psychology, William James remarked that few people bring to bear more than about 10% of their human potential on the problems and challenges of living. Others since James, though changing the percentages somewhat, have said substantially the same thing, and few have challenged their statements. It is probably not an exaggeration to say that unused human potential constitutes a more serious social problem than emotional disorders, because it is more widespread. People with problems have unused opportunities. People who are relatively problemless have unused opportunities. If this is the case, then most clients you meet will have unused opportunities that can play a role in helping them manage their problem situation. Pursuing an opportunity can be a way of transcending rather than “solving” a problem.

In the following case, two entrepreneurs meet. The client, Johaiven (J), is a business entrepreneur. He is running a reasonably successful apps business, specializing in apps related to travel. He is talking with a counselor because he

has had obsessive-compulsive episodes over the past four years. While these episodes are annoying rather than disabling, he has decided that he would like to do something about them. Otherwise, he is in good psychological health. The counselor, Kenner (K), uses entrepreneurial approaches to helping (see the list of the characteristics of entrepreneurs in Chapter 3) when they are fitting. He uses the helping model described in the pages of this book, but he finds inventive ways of using both stages and tasks. He creatively adapts the model to the needs of each client. What follows is an edited form of their dialogue.

**K:** Well, Johaiven, what can I do to help?

**J:** I've got a dash of OCD trouble. It hits me mainly when I'm driving around quieter neighborhood, not on freeways. When I get distracted, I think I might have hit someone, say, a child. So I go around the block to make sure that I didn't. Sometimes I go around more than once because, of course, I could have hit someone while checking. But then I catch myself and say to myself, "There you go again, idiot." And I get back on track.

**K:** So the ethical part of you grabs hold of you for a while. I mean ethical people go out of their way to correct their mistakes.

**J:** So while OCD is bad—I think the D stands for disease or disorder—in this case it says something good about me, about my ethics. I like that part.

**K:** When you "come to your senses," what do you say to yourself?

**J:** "There you go again, idiot."

**K:** So in your case you do not look at it as a disease or a disorder. When you say, "There you go again," it sounds like you're saying, "There's that bad habit again."

**J:** You think it's just a bad habit?

**K:** Forget the "just" part. But maybe we can deal with it as a bad habit. I bet that you, like me and everyone else, have had to face up to a number of bad habits over your life span.

**J:** Of course, but I guess I never thought that all or most bad habits have something in common.

At this point K gives a very brief but practical summary of what we know about life-limiting habits.

**J:** Well, from what you say this could be just a bad habit. . . . I take the "just" part back because it does interfere with my life.

K then briefly describes what can be done to manage unwanted habits and helps J apply the principles to his OCD episodes.

Kenner helps Johaiven spot and use two opportunities. The first relates to the "goodness" hidden in the OCD episodes, Johaiven's basic decency. He habitually tries to do what is right. The second opportunity is to move away from talk about disease and disorder, which are disturbing psychological realities, to a discussion of ordinary life-limiting habits.

Clients are much more likely to talk about problem situations than about unused opportunities. That's a pity because clients can often manage many problems better by developing unused opportunities instead of dealing directly with their problems. Alisa offers a nice example. She tends to see her worth and happiness through the narrow lens of being in a romantic relationship. Rena spots this early and thinks that Alisa should broaden her lens by looking at other things in her life that she has more control over that might contribute to her sense of worth. Box 9.1 lists questions you can help clients ask themselves concerning opportunities.

### Help Clients See Every Problem as an Opportunity

This goes deeper, perhaps a bit more entrepreneurial. Some say that there are always one or more opportunities buried in the problem situation itself. Although there is no justification for romanticizing pain, the flip side of a problem can be an opportunity. Here are few examples.

- Kevin used his diagnosis of AIDS as a starting point for reintegrating himself into his extended family and challenging the members of his family to come to grips with some of their own problems, problems they had been denying for a long time.
- Beatrice used her divorce as an opportunity to develop a new approach to men based on mutuality. Because she was on her own and had to make her own way, she discovered that she had entrepreneurial skills. She started an arts and crafts company.
- Jerome, after an accident, used a long convalescence period to review and reset some of his values and life goals. He began to visit other patients in the rehabilitation center. This gave him deep satisfaction. He began to explore opportunities in the helping professions.
- A couple mourning the death of their only child started a day care center in conjunction with other members of their church.

#### BOX 9.1

#### Opportunity-Finding Questions for Clients

Here are some questions counselors can help clients ask themselves to identify unused opportunities.

- What are my unused skills/resources?
- What are my natural talents?
- What resources are available to me in my environment?
- How could I use some of these to enhance my life?
- Which opportunities would help me transcend my problems?
- What opportunities do I let go by?
- What ambitions remain unfulfilled?
- What could I accomplish if I put my mind to it?
- Which opportunities should I be developing?
- Which role models could I be emulating?

William C. Miller (1986) talked about one of the worst days of his life. Everything was going wrong at work. Projects were not working out, people were not responding, the work overload was bad and getting worse—nothing but failure all around. Later that day, over a cup of coffee, he took some paper, put the title “Lessons Learned and Relearned” at the top, and wrote down as many entries as he could. Some hours and seven pages later, he had listed 27 lessons. The day turned out to be one of the best of his life. So he began to keep a daily “Lessons Learned” journal. It helped him avoid getting caught up in self-blame and defeatism. Subsequently, on days when things were not working out, he would say to himself, “Ah, this will be a day filled with learning!” Sometimes helping a client spot a small opportunity, be it the flip side of a problem or a standalone opportunity, provides enough leverage to put him or her on a more constructive tack.

Rena believes that the chaos itself is an opportunity. Alisa will get nowhere if all she does is move from one problem to another. The fact that her life is so chaotic and miserable can be a motivator. Perhaps the starting point should not be any of her problems. Helping her draw a picture of what kind of life she wants might be more useful.

### As Clients Tell Their Stories, Help Them Search for Unused Resources

Incompetent helpers concentrate on clients’ deficits. Skilled helpers, as they listen to and observe clients, do not blind themselves to deficits, but they are quick to spot clients’ resources, whether used, unused, or even abused. These resources can become the building blocks for the future. Consider this example:

Terry, a young woman in her late teens who has been arrested several times for street prostitution, is an involuntary, or “mandated,” client. The charge this time is possession of drugs. She ran away from home when she was 16 and is now living in a large city on the East Coast. Like many other runaways, she was seduced into prostitution “by a halfway decent pimp.” Now she is very street-smart. She is also cynical about herself, her occupation, and the world. She is forced to see a counselor as part of the probation process. As might be expected, Terry is quite hostile during the interview. She has seen other counselors and sees the interview as a game. The counselor already knows a great deal of the story because of the court record. The dialogue is not easy. Some of it goes like this: Terry has obvious deficits. She is engaged in a dangerous and self-defeating lifestyle. But as the counselor listens to Terry, he spots many different resources. Terry is a tough, street-smart woman. The very virulence of her cynicism and self-hate, the very strength of her resistance to help, and her almost unchallengeable determination to go it alone are all signs of resources. Many of her resources are currently being used in self-defeating ways. They are misused resources, but they are resources nevertheless. Helpers need a resource-oriented mind-set in all their interactions with clients. Contrast two different approaches.

**CLIENT:** I practically never stand up for my rights. If I disagree with what anyone is saying—especially in a group—I keep my mouth shut.

**COUNSELOR A:** So clamming up is the best policy. . . . What happens when you do speak up?

**CLIENT (pausing):** I suppose that on the rare occasions when I do speak up, the world doesn’t fall in on me. Sometimes others do actually listen to me. But I still do not seem to have much impact on anyone.



**COUNSELOR A:** So speaking up, even when it's safe, doesn't get you much.

**CLIENT:** No, it doesn't.

Counselor A, sticking to sharing highlights, misses the resource mentioned by the client. Although it is true that the client habitually fails to speak up, he has some impact when he does speak. Others do listen, at least sometimes, and this is a resource. Counselor A emphasizes the deficit. Let's try another counselor.

**COUNSELOR B:** So when you do speak up, you don't get blasted, you even get a hearing. Tell me what makes you think you don't exercise much influence when you speak?

**CLIENT (pauses):** Well, maybe influence isn't the issue. Usually I don't want to get involved. Speaking up gets you involved.

Note that both counselors try to respond with empathy, but they focus on different parts of the client's message. Counselor A emphasizes the deficit; Counselor B focuses on an asset and follows up with a probe. This produces a significant clarification of the client's problem situation. Now not wanting to get involved is an issue to be explored.

The search for resources is especially important when the story being told is bleak. I (GE) once listened to a man's story that included a number of bone-jarring life defeats—a bitter divorce, false accusations that led to his dismissal from a job, months of unemployment, serious health concerns, months of homelessness, and more. The only emotion the man exhibited during his story was depression. Toward the end of the session, we had this interchange:

**HELPER:** Just one blow after another, grinding you down.

**CLIENT:** Grinding me down, and almost doing me in.

**HELPER:** Tell me a little more about the "almost" part of it.

**CLIENT (hesitates):** Well, I'm still alive, still sitting here talking to you.

**HELPER:** Despite all these blows, you haven't fallen apart. That seems to say something about the fiber in you.

At the word fiber, the client looked up, and there seemed to be a glimmer of something besides depression in his face. I put a line down the center of a newsprint pad. On the left side I listed the life blows the man had experienced. On the right I put "Fiber." Then I said, "Let's see if we can add to the list on the right side." We came up with a list of the man's resources. His "fiber" included his musical talent, his honesty, his concern for and ability to talk to others, and so forth. After about a half hour, he smiled weakly, but he did smile. He said that it was the first time he could remember smiling in months.

Alisa keeps describing herself as helpless in the face of all of her problems. The reality is that she is not helpless. Rena's job is to help her find the resources both within her and around her to manage the chaos of her life. One way of doing this is to help her see that there are opportunities embedded in any problem situation. Often enough, the more complex the problem situation is, the more likely the opportunities. As we will see in the next section, helping clients find

the opportunity and the resources needed to take advantage of any given the opportunity should always be part of the storytelling process.

## I-B: Use Self-Challenge to Help Clients Tell the Real Story **LO 9.3**

As we have seen, the purpose of Stage I is to help clients tell their stories in a way that opens them up and motivates them to do something. All three inter-related and inter-mingled tasks—A, B, and C—work together to do just that. Take another look at the graphic for Stage I in Figure 9.1.

We have already seen many examples of Task I-B, especially in Chapter 7 where the communication skills needed to invite clients to self-challenge are outlined. In other words, the communication skills illustrated in Chapter 7 are of the essence of Task I-B. In Task I-B, counselors use these skills to help clients work through blind spots and develop the kind of new perspectives that lead to new problem-managing and opportunity-developing behavior. The “real” story gives an accurate picture of the client’s problem situation. If the client says, “It’s never my fault; my spouse is always the cause of our trouble,” we most likely do not have **the real story**. Task I-B skills can be used to help clients uncover hidden concerns, clarify vague issues, add important details, explore clients’ hesitations, see their problems from a more constructive perspective, add important information and details that are being left out, find unused strengths and resources, and spot and explore opportunities buried in or masked by problem situations.

### Determine the Real Story in the Case of Alisa

Alisa probably has a number of blind spots. Let’s suppose that Alisa insists on talking about the problems she has had with boyfriends. She maintains that having the “right man” in her life is of central importance. On the other hand, these relationships tend to fail. In some way she ends up being “mistreated” by the boyfriends she chooses to be with.

**ALISA** (*eyes cast downward, sadly says*): I just wished I could find someone to share my life with, to find someone who loves me for who I am. That’s all I need.

**RENA**: That is understandable; most of us want that. But for you happiness has been frustratingly elusive. Your relationships never seem to be what you had hoped they would be. I imagine that you have been asking yourself, “What’s going on here?”

**ALISA**: Well, all of my relationships have really been disasters. I just haven’t found the right guy, they all end up taking advantage of me, they. . . .

**RENA** (*gently interrupting*): Alisa, let’s try to take a deeper look at this, you know, see it from different angles that you might find helpful. You say you always end up with the wrong guy. Help me understand how it is you have had such terrible luck. You are bright, attractive, funny, and seem to be quite caring. Are all the single guys here that bad? (They both laugh).

**ALISA:** Maybe. . . . I guess I just get desperate and the first guy who shows an interest in me, I jump on board without much thought.

**RENA:** So your needs are so strong that you're willing to take chances. I wonder what kind of pressure that puts on both of you. I'm wondering if something about this is unfair to both of you.

**ALISA:** No doubt. Yep, I end up trying too hard and not really focusing on whether this guy is the right guy for me or we are a good fit. That leads to all sorts of problems. And I feel so needy.

**RENA:** How broad is your life?

**ALISA:** I'm not sure what you mean.

**RENA:** Well, you're putting so much emotional energy into getting the right guy. . . . I'm wondering if you have much time for anything else, especially because you seem to have so many resources.

**ALISA:** Well, once I get the right guy, I could do all sorts of things.

**RENA:** Let's forget the "right guy" for a minute. What else do you want out of life?

**ALISA:** It is like you said earlier—I do have some smarts, I was a good student. I would like to finish school and upgrade my career.

**RENA:** Let's explore that a bit.

They go on to talk about what Alisa, given her resources, could do with her life. Here is an interchange later in the session.

**ALISA:** Wait a minute. Have you been saying that my preoccupation with getting the right man in my life is screwing up the rest of my life?

**RENA:** I'm not saying that, but I think that we are exploring that possibility. You're the only one who would really know the answer to your question.

**ALISA:** Well, talking about the possibilities I could pursue has made me, well, excited. This is the best conversation I've had for months. Maybe I've got things backward. First, get a life. Then get a man. I am so tired of this needy person living inside of me!

**RENA:** OK. Let's draw up a picture of what "get a life" would look like.

A challenged blind spot leads to a new perspective. They go on to work together on identifying possibilities for a different, more creative future. Opportunities rather than problems are now center stage.

### Help Clients Challenge the Quality of Their Participation

In Chapter 7 we have seen a number of examples of counselors helping clients engage in different kinds of self-challenge. In this chapter the self-challenge focus is on helping clients get the most out of the helping process. Clients benefit by owning and participating as fully as possible in the helping process. This section

focuses on some of the challenges to engagement in the helping process itself that clients face. As we have seen, even clients whose goodwill is beyond doubt can have trouble participating for a variety of reasons. Here are some principles you can use to help clients challenge themselves to participate as fully and as intelligently as possible. They are principles and not must-do rules. Use them when they benefit your clients.

***Invite clients to own their problems and unused opportunities*** Sometimes clients are reluctant or even refuse to take responsibility for their problems and unused opportunities. Instead, there is a whole list of outside forces and other people who are to blame. Although there may be truth in these reasons, helpers have to take care not to stay mired in these reasons with their clients. Therefore clients may need to challenge themselves to own the problem situation more fully.

Avoiding responsibility is especially easy when there is indeed someone else to blame. Take the case of a client who feels that her business partner has been pulling a fast one on her. He's made a deal on his own. She's alarmed, but she hasn't done anything about it so far. Let us say that three different helpers, A, B, and C, respond. Consider how their empathic responses differ.

**HELPER A:** You feel angry because he unilaterally made the decision to close the deal on his terms.

**HELPER B:** You're angry because your legitimate interests were ignored.

**HELPER C:** You're furious because you were ignored, your interests were not taken into consideration, maybe you were even financially victimized, and you let him get away with it.

Challenging clients in terms of ownership means helping clients understand that in some situations they may have some responsibility for creating or at least perpetuating their problem situations. Statement C does precisely that—"You let him get away with it."

Not only problems but also opportunities need to be seized and owned by clients. As Wheeler and Janis (1980) note, "Opportunities usually do not knock very loudly, and missing a golden opportunity can be just as unfortunate as missing a red-alert warning" (p. 18). Consider Tess and what some refer to as a "quarter life crisis."

Tess was a strong student who was always known as the driven one in her family and everyone agreed was destined for success. Meticulous and goal-driven, she graduated college in 3 years with honors and had her pick of dental schools. In the middle of her first year of dental school, Tess finds herself uninterested in her studies and begins to have significant doubt about becoming a dentist. She seeks the help of a counselor who has an office in the dental school.

*Tess:* I have never felt this way before. I have always just kept my head down and worked. My grades are okay still, but I dread going to class and then dread studying. I need help getting motivated again.

*Counselor:* So, this is the first time you have really taken the time to look up from your work and see what is going on?

*Tess:* Yeah, and I feel so guilty for doing so. I mean I should be focused on my work; there is so much to do as a first year. I am sure you already know that though.

*Counselor:* The first year is undoubtedly tough. Is that part of your concern, the difficulty and rigor?

*Tess:* I thought about that, but that is not it—I like being challenged and do not mind working hard. I am just not sure if dentistry or any medical profession is right for me. That feels so scared to say out loud. Gosh, everyone has invested so much in me being here. I have invested so much to be here! My guess is most new students feel that way and I will snap out of it. Can you help me to do that?

*Counselor:* Perhaps. However, I want to make sure that we are not passing up something that is important here. You seem to typically move fast, you get things done. I wonder if this is an opportunity, maybe even a gift for you, to take a closer look at your pursuit of a dental degree and to ask why you are not happy right now in dental school?

*Tess (after a long pause):* I never viewed this as an opportunity, but as a problem I needed to fix so I could get my focus back on my studies. But maybe you are right. I had been viewing it as being stuck. Maybe this is a chance for me to really understand what I am doing here and why I'm even here.

For Tess it is about reframing her “stuckness” as an opportunity. For the first time, to really ask herself what she wants to do for her career free of expectations of others. Understanding her lack of motivation rather than prematurely going in to “fix it” is getting at **the right story** for Tess.

***Invite clients to state their problems as solvable*** Jay Haley (1976, p. 9) said that if “therapy is to end properly, it must begin properly—by negotiating a solvable problem.” Or exploring a realistic opportunity, someone might add. It is not uncommon for clients to state problems as unsolvable. This justifies a “poor-me” attitude and a failure to act.

*Unsolvable Problem:* In sum, my life is miserable now because of my past. My parents were indifferent to me and at times even unjustly hostile. If only they had been more loving, I wouldn't be in this mess. I am the failed product of an unhappy environment.

Of course, clients will not use this rather stilted language, but the message is common enough. The point is that the past cannot be changed. As we have seen, clients can change their attitudes about the past and deal with the present consequences of the past. Therefore when a client defines the problem exclusively as a result of the past, the problem cannot be solved. “You certainly had it rough in the past and are still suffering from the consequences now” might be the kind of response that such a statement is designed to elicit. The client needs to move beyond such a point of view.

A solvable or manageable problem is one that clients can do something about. Consider a different version of the foregoing unsolvable problem. Aileen has had a rough childhood. Her parents *were* mean to her. She finally went out on her own and her parents didn't seem to care.

*Solvable Problem:* Over the years I've been blaming my parents for my misery. And I do not want to let them off the hook. But I still spend a great deal of time feeling sorry for myself. As a result, I sit around and do nothing. I do not make friends, I do not involve myself in the community, and I do not take any constructive steps to get a decent job.

This message is quite different from that of the previous client. The problem is now open to being managed because it is stated almost entirely as something the client does or fails to do. The client can stop wasting her time blaming her parents, because she cannot change them; she can increase her self-esteem through constructive action and therefore stop feeling sorry for herself; and she can develop the interpersonal skills and courage she needs to enter more creatively into relationships with others. She can create a different future.

This does not mean that all problems are solvable by the client's direct action. A teenager may be miserable because his self-centered parents are constantly squabbling and seem indifferent to him. He certainly can't solve the problem by making them less self-centered, stopping them from fighting, or getting them to care for him more. But he can be helped to find ways to cope with his home situation more effectively by developing fuller social opportunities outside the home. This could mean helping him develop new perspectives on himself and family life and challenging him to act both internally and externally in his own behalf.

***Invite clients to explore their “problem-maintenance structure”*** Pinsof (1995) points out how important it is to explore with clients the “actions, biology, cognitions, emotions, object relations, and self-structures” (p. 7) that keep them mired in their problems. What he calls the “**problem-maintenance structure**” (p. 7) refers to the set of factors—including personal, social, organizational, community, and political factors—that keeps clients from identifying, exploring, and ultimately doing something about their problem situations and unused opportunities. “You say that you do not like the way you relate to people. What is it that you do not like? And what is it that keeps that style in place? What gets in the way of your changing it?”

The work of helping clients “restructure” self-defeating defenses, cognitions, patterns of emotional expression, self-focused and outward-focused behavior, relationships, and approaches to the environment (Greenberg, 2011; see Magnavita, 2005, Chapters 7–10) begins in Stage I.

### ***Invite clients to move on to the right stage and task of the helping process***

We have touched on this already in discussing probing. There is no reason to keep going over the same issue with clients. You can help clients challenge themselves to do the following:

- Clarify problem situations by describing specific experiences, behaviors, and feelings when they are being vague or evasive
- Talk about issues—problems, opportunities, goals, commitment, strategies, plans, actions—when they are reluctant to do so
- Develop new perspectives on themselves, others, and the world when they prefer to cling to distortions

- Review possibilities, critique them, develop goals, and commit themselves to reasonable agendas when they would rather continue wallowing in their problems
- Search for ways of getting what they want, instead of just talking about what they would prefer
- Spell out specific plans instead of taking a scattered, hit-or-miss approach to change
- Persevere in the implementation of plans when they are tempted to give up
- Review what is and what is not working in their pursuit of change “out there”

In sum, you can help clients challenge themselves to engage more effectively in all the stages and tasks of problem management during the sessions themselves and in the changes they are pursuing in their everyday life.

### Consider the Wider Use of Self-Challenge

Chapter 7 introduces the concept of inviting clients to challenge themselves. Ancient Greek wisdom tells us “the unexamined life is not worth living.” But because self-examination leads naturally to self-challenge, it is just as true to say that “the unchallenged life is not worth living.” However, these bits of wisdom are not science. They are values; they are choices that people can make. It is not our job to make choices for our clients, but I believe that it is our job to help clients set the scene so that that can make their own choices intelligently. As we shall see in Stage II, clients cannot make reasonable choices for a better future without first understanding the *possibilities* for a better future.

I’ve often thought that helping needs to be different from everyday life if it is to make a difference. That is, therapy itself is, or should be, a challenging experience. We do our clients a disservice if we water it down. If collaboration with our clients is of the essence of therapy, then they should have a good idea of the resources we bring to the table. This means, not just the helping model or approach to treatment, but the fiber and substance of the moves and methods within the problem-management approach. Self-challenge should permeate the entire process.

## I-C: Help Clients Focus on the Right Story LO 9.4

Skillful counselors help clients make and carry out decisions that make a difference in their lives. Many clients have a range of issues. Alisa certainly does. In that case help such clients choose issues that will make a significant difference in their lives. If a client wants to work only on trivial things or does not want to work at all, then it might be better to defer counseling.

### Return to the Alisa-Rena Case

Review some of the things Rena did to help Alisa focus on the “right” issues, that is, issues, which if managed, would make a substantial difference in her life.

Rena summarizes several of Alisa’s concerns—feeling depressed and anxious, viewing her self-worth through the lens of her social and romantic life, wanting to go back to school, relationships with her family, and exploring her personal cultural



identity—and asks where it feels most important to start. As they sort through the issues, Alisa and Rena agree that many of her issues are interrelated and that some of them seem to have a bit of a “chicken and egg” quality to them.

Two broad issues emerge as central. The first focuses on failed romantic relationships. The second involves what Alisa calls “a normal life” which she defines as a decent career (she uses the term career rather than job) together with a decent social life that involves community of some kind. Alisa desperately wants to do something about her romantic life. She’s decent, intelligent, a doer—so, she keeps asking herself what’s wrong? Rena realizes that Alisa has a range of blind spots around romantic relationship. She fails to see that romance is a bit like happiness. Happiness can’t be pursued in and of itself. Romance isn’t an end in itself either. It slips away too quickly even in the best of relationships, but that’s all right because of the deep satisfaction in solid relationships.

Rena suggests backing away from discussions focusing on “getting the right guy” until they explore what the overall context for such a relationship should look like. It’s as if the guy is asking, “What does the whole picture look like?” Relationships do not exist in a vacuum. What is the guy looking for besides romance? This helps Alisa focus on what her life should look like. It should focus on what kind of life she wants, aside from the relationship. Rena makes sure they do not focus on the kind of life style needed to “get” the guy. The approach opens up a whole new world.

As they continue their work, at the beginning of each session Rena gets feedback from Alisa as to the impact of the previous session. At the end of the session they give each other feedback with respect to how the relationship is going and discuss what actions Alisa needed to take between sessions.

### **Apply the Principles for Helping Clients Choose Issues That Will Make a Difference in Their Lives**

Helping is expensive both financially and psychologically. It should not be undertaken lightly. Therefore a word is in order about what might be called the “economics” of helping, helping clients set priorities. The term “value” is used to introduce the economics of helping. How can we help our clients get the most out of the helping process? Helpers need to ask themselves, “Am I adding value through each of my interactions with this client?” Clients need to be helped to ask themselves, “Am I working on the right things? Am I spending my time well in these sessions and between sessions?” The question here is not “Does helping help?” but “Is helping working in this situation? Is it worth it?”

There are many ways that we can help clients create value. First of all, they create value by working on the right things, addressing issues that will make some kind of substantive difference in their lives. They also create value through the quality of their participation in the helping process and by making the right decisions. In the end it is their process and they can make it value-added or not. The process of routinely getting feedback from clients has been discussed in this book. Using measures to monitor progress of treatment and the working relationship (Duncan & Reese, 2015; Lambert, 2014) has been empirically demonstrated to improve treatment outcome. The process ensures that helpers are providing the quality of care that clients are seeking and that the limited resources of both client and helper are deployed most effectively.

The following principles of getting value from the helping process serve as guidelines for choosing issues to be worked on. These seven principles overlap; more than one may apply at the same time. They are not the only principles and in your mind they not be the “right” set. Eventually, you will formulate your own set of principles.

- Determine whether or not helping is called for or should be continued.
- If there is a crisis, first help the client manage the crisis.
- Begin with the issue that seems to be causing the client the most pain.
- Begin with issues the client sees as important and is willing to work on.
- Begin with some manageable subproblem of a larger problem situation.
- Move as quickly as possible to a problem that, if handled, will lead to some kind of general improvement.
- Focus on a problem for which the benefits will outweigh the costs.

Underlying all these principles is an attempt to make clients’ initial experience of the helping process rewarding so that they will have the incentives they need to continue to work. These principles are guidelines, not a set of step-by-step directives. The outcome is important: clients working on issues that will make a difference in their lives.

### ***Determine whether or not helping is called for or should be continued***

Relatively little is said in the literature about screening—that is, about deciding whether any given problem situation or opportunity deserves attention. The reasons are obvious. Helpers-to-be are rightly urged to take their clients and their clients’ concerns seriously. They are also urged to adopt an optimistic attitude, an attitude of hope, about their clients. Finally, they are schooled to take their profession seriously and are convinced that their services can make a difference in clients’ lives. For those and other reasons, the first impulse of the average counselor is to try to help clients no matter what the problem situation might be.

There is something very laudable in this. It is rewarding to see helpers prize people and express interest in their concerns. It is rewarding to see helpers put aside the almost instinctive tendency to evaluate and judge others and to offer their services to clients just because they are human beings. However, like other professions, helping can suffer from the “law of the instrument.” A child, given a hammer, soon discovers that almost everything needs hammering. Helpers, once equipped with the models, methods, and skills of the helping process, can see all human problems as needing their attention. In fact, in many cases, counseling may be a useful intervention but one in which the costs outweigh the benefits.

It is important that the client-helper dialogue determine whether the client is ready to invest in constructive change or not. And to what degree. Change requires work on the part of clients. If they do not have the incentives to do the work, they might begin and then trail off. If this happens, it’s a waste of resources. For instance, Ian and Gretchen are mildly dissatisfied with their marriage and seem to be looking for a “psychological pill” that will magically make things better. There seem to be few incentives for the work required to

reinvent the marriage. Their dialogue with each other and with the counselor casts doubt on their readiness for change. Further dialogue needs to focus on whether they want to get involved with the work counseling requires. The counselor need not make a unilateral decision and end up saying: “I do not think this is going to work.” The decision should emerge from the dialogue between helper and client.

Although helpers and clients together must make a decision in each case, the possibility of no treatment deserves serious attention. However, it goes without saying that screening should not be done in a heavy-handed way. Statements such as the following are not useful:

- “Your concerns are actually not that serious.”
- “You should be able to work that through without help.”
- “I do not have time for problems as simple as that.”

Whether such sentiments are expressed or implied, they obviously indicate a lack of respect and constitute a caricature of the screening process.

Interrupting treatment—the no-further-treatment option—can do a number of useful things: interrupt helping sessions that are going nowhere or are actually destructive; keep both client and helper from wasting time, effort, and money; delay help until the client is ready to do the work required for constructive change; provide a “breather” period that allows the client to consolidate gains from previous treatments; provide the client with an opportunity to discover that he or she can do without treatment; keep helper and client from playing games with themselves and one another; and provide motivation for the client to find help in his or her own daily life. However, helping professionals’ decision not to treat or to discontinue treatment that is proving fruitless is countercultural and is therefore difficult to make.

We offer some practical guidelines for considering if treatment is the right option:

- Use a feedback system that assesses well-being or level of distress at the beginning of counseling to help determine severity of an issue
- Ask “Am I the right person, at the right time, for this person’s particular issue? Or is something else needed?”
- Ask “What other interventions or treatments might be helpful?”

Of course, effective helpers do more than these things. They listen well and are empathic, pick up clues relating to a client’s commitment, but they do not jump to conclusions. Empathy, as we have seen, is a two-way street and clients often have their private logic, which needs to be understood. Helpers test the waters in various ways. If clients’ problems seem inconsequential, they probe for more substantive issues. If clients seem reluctant, resistant, and unwilling to work, they challenge clients’ attitudes and help them work through their resistance. But in both cases they realize that there may come a time, and it may come fairly quickly, to judge that further effort is uncalled for because of lack of results. It is better, however, to help clients make such a decision themselves or challenge them to do so. In the end, the helper might have to call a halt, but his or her way of doing so should reflect basic counseling values.

***If there is a crisis, first help the client manage the crisis*** Phillip Kleespies (2009) has put together a book dealing with “behavioral emergencies.” Crises in clients’ lives are usually forms of behavioral emergencies. Kleespies focuses on risk for suicide, violence, and victimization but also discusses common emergency-related crises such as self-injury, personality disorders, and substance abuse such as being caught in the meth trap. Mendenhall (2007), a medical family therapist, gives a striking account of the crises he faces and defuses in the emergency room, trauma units, and hospital wards. Although crisis intervention is sometimes seen as a special form of counseling (France, 2005), it can also be seen as a rapid application of the three stages of the helping process to the most distressing aspects of a crisis situation.

*Principle Violated.* Zachary, age 20, is an employee who works as a cashier at a large retailer and is also completing college courses on-line rushes in to see his shift manager. “My fiancé just wiped out my entire bank account, maxed out my credit card, and has not paid our rent or bills in several months. We are going to be evicted! She told me she has been gambling online and got hooked.” The manager quickly said he was sorry but that he could not give him more hours. He then said it was a tough way to learn that you can trust others when it comes to money. He then asked if he thought she was going to be coming to the store and making a scene. Zachary becomes increasingly frustrated, “I do not need to be lectured right now. I need help of what to do!” The store manager apologized and suggested he use an office upstairs to call the Employee Assistance Program that offers telephonic counseling for the company. Zachary, desperate for help, reluctantly agrees.

*Principle Used.* Zachary is connected with a counselor, Sheila, and after brief introductions, Sheila says, “You sound overwhelmed. Tell me what is going on.” She listens to Zachary’s account of what has happened, interrupting very little, merely putting in a word here and there to let him know she is with him and asking a couple of questions to make sure she understands the issues. But generally, she permits Zachary to tell his story, to cry, to be angry, and then slowly and reassuringly “talks Zach down,” engaging in an easy dialogue that allows him to get his composure again. Zachary and Sheila talk about his feelings of betrayal and also concern of what to do about all of the bills and how he will pay for college. And he is also concerned about what to do about his relationship with his fiancé. But he is most concerned about how to handle the eviction notice. With Sheila’s help, he begins to discuss possibilities.

Sheila does what she can to defuse the immediate crisis and helps Zachary take the next crisis-management step. We use a compressed version of the problem-management process outlined in this book to help clients defuse crises. In helping clients defuse crises, it is important to focus on the context in which the crisis takes place (Myer & Moore, 2006). Because the client is often only one of the stakeholders, a client-only focus can be simplistic and ineffective.

***Begin with an issue that seems to be causing the most pain*** Clients often come for help because they are hurting even though they are not in crisis. Helping them use their hurt as an incentive to work on their problems, then, is a way of adding value. Their pain also makes them vulnerable. If it is evident that they are open to influence because of their pain, seize the opportunity, but move cautiously. Their pain may also make them demanding. They can’t understand why you cannot help them get rid of it immediately. This kind of

impatience may put you off, but it, too, needs to be understood. Such clients are like patients in the emergency room, each seeing himself or herself as needing immediate attention. Furthermore, their demands for immediate relief may well signal a self-centeredness that is part of the broader problem situation. It may be that their pain is, in your eyes, self-inflicted, and ultimately you may have to challenge them on it. But pain, whether self-inflicted or not, is still pain. Part of your respect for clients is your respect for them as vulnerable.

*Principle Violated.* Rob, a man in his mid-20s, comes to a counselor in great distress because his wife has just left him. The counselor's first impression is that Rob is an impulsive, self-centered person with whom it would be difficult to live. The counselor immediately challenges him to take a look at his interpersonal style and the ways in which he alienates others. Rob seems to listen, but he does not return.

*Principle Used.* Rob goes to a second counselor, who also sees a number of clues indicating self-centeredness and a lack of maturity and discipline. However, she listens carefully to his story, even though it is one-sided and overly complicated. She explores with him the incident that precipitated his wife's leaving. Instead of adding to his pain by making him come to grips with his selfishness, she focuses on what he wants for the future, especially the immediate future. Of course, Rob thinks that his wife's return is the most important part of a better future. She says, "I assume she would have to be comfortable with returning." He says, "Of course." She asks, "What could you do on your part to help make her more inclined to want to return?" His pain provides the incentive for working with the counselor on how he might need to change even in the short term.

The second helper does not use pain as a club. However guilty he might be, Rob didn't need his nose rubbed in his pain. The counselor helps Rob use his pain as an incentive to deal with the critical issues of his life. What is Rob willing to do to rid himself of his pain and create the future he says he wants?

Alisa's most intense pain comes from the rejection felt from another failed relationship. She thought that she had made her needs secondary to his, but this was not enough to maintain the relationship. In fact, that's not the way he saw it. Remember, he felt "smothered." Once more she saw herself as fundamentally flawed and unlovable. Rena started there, listening with empathy but avoiding conspiratorial sympathy. She keeps looking for ways to "nudge" Alisa toward a more constructive dialogue. Her empathy did "buy her points." Alisa's gratitude consisted in becoming more open to the helping process and its possibilities.

### ***Begin with issues the client sees as important and is willing to work on***

The frame of reference of the client is a starting point in the search for value. Given the client's story, you may think that he or she has not chosen the most important issues for initial consideration. However, helping clients work on issues that are important in their eyes sends an important message: "Your interests are important to me."

*Principle Violated.* A woman comes to a counselor complaining about her relationship with her boss. She believes that he is sexist. Male colleagues not as talented as she is get the best assignments and a couple of them are promoted. After listening to her story, the counselor has her explore her family background for "context." After listening, he believes that she probably has some leftover developmental issues with her father and

an older brother that affect her attitude toward older men. He pursues this line of thinking with her. She is confused and feels put down. When she does not return for a second interview, the counselor tells himself that his hypothesis has been confirmed.

*Principle Used.* The woman seeks out a lawyer who deals with equal-opportunity cases. The lawyer, older and not only smart but wise, listens carefully to her story and probes for missing details. Then he gives her a snapshot of what such cases involve when they go to litigation. Against that background, he helps her explore what she really wants. Is it more respect? more pay? a promotion? revenge? a different kind of boss? a better use of her talents? a job in a company that does not discriminate? Once she names her preferences, he discusses with her options for getting what she wants. Litigation is not one of them.

The first helper substituted his own agenda for hers. He turned out to be somewhat sexist himself. The second helper accepted her agenda and helped her broaden it. He saw no value in litigation, but he did suggest that her problem situation could be an opportunity to reset her career. He suspected that there were plenty of firms eager to employ people of her caliber.

### ***Begin with some manageable subproblem of a larger problem situation***

Large, complicated problem situations often remain vague and unmanageable. Dividing a problem into manageable bits can clarify where value lies. Most larger problems can be broken down into smaller, more manageable subproblems.

*Principle Violated.* Aaron and Ruth, in their mid-50s, have a 25-year-old son living with them who has been diagnosed as schizophrenic. Aaron is a manager in a manufacturing company that is in economic difficulty. His wife has a history of panic attacks and chronic anxiety. All these problems have placed a great deal of strain on the marriage. They both feel guilty about their son's illness. The son has become quite abusive at home and has been stigmatized by people in the neighborhood for his "odd" behavior. Aaron and Ruth have also been stigmatized for "bringing him up wrong." They have been seeing a counselor who specializes in a "systems" approach to such problems. They are confused by his "everything is related to everything else" approach. They are looking for relief but are exposed to more and more complexity. They finally come to the conclusion that they do not have the internal resources to deal with the enormity of the problem situation and drop out.

*Principle Used.* A couple of weeks pass before they get the courage to contact a psychiatrist, Meryl, whom a family friend has recommended highly. Although Fiona understands the systemic complexity of the problem situation, she also understands their need for some respite. She first sees the son and prescribes some anti-psychotic medication. His odd and abusive behavior is significantly reduced. Even though Aaron and his wife are not actively religious, she also arranges a meeting with a rabbi from the community known for his ecumenical activism. The rabbi puts them in touch with an ecumenical group of Jews and Christians who are committed to developing a "city that cares" by starting up neighborhood groups. Involvement with one of these groups helps diminish their sense of stigma. They still have many concerns, but they now have some relief and better access to both internal and community resources to help them with those concerns.

The psychiatrist helps them target two manageable subproblems—the son's behavior and the couple's sense of isolation from the community. Some immediate relief puts them in a much better position to tackle their problems longer



term. There are, indeed, serious family systems issues here, but theories and methodologies should not take precedence over the client's immediate needs.

Alisa's full plate of concerns led to her going to see the doctor for help. Rena didn't try to take on all of Alisa's problems. She methodically helped her understand her problems more clearly. Clarity helped make it easier to decide what to work on. Rena's experience had taught her that problems often seem more manageable when "the cards are on the table," as it were. Alisa began to talk about behavior for which she was ashamed. A much fuller story began to unfold. It became easier to move from problem and shame to opportunities and hope. No magic, just hard work on the basics.

***Move as quickly as possible to a problem that, if handled, will lead to some kind of general improvement*** Some problems, when addressed, yield results beyond what might be expected. This is the spread effect.

*Principle Violated.* Danesha, a 49-year-old middle manager, talks with her coach about how to address the insomnia that is starting to reduce her effectiveness at work. She yawns during meetings, feels groggy throughout the day. Her thinking feels clouded, and she has had to take short naps. Others are beginning to notice. She is falling behind on some projects because she simply does not have the energy to push through the day the way she had before. To help, her coach teaches her some behavioral strategies, including progressive muscle relaxation, which have some benefit initially, but do not really change the picture. Her sleeping problems persist and she begins to feel depressed. After telling her coach she is still having problems, he teaches her some cognitive strategies (e.g., being aware of negative self-talk) that might help soothe her worry and thinking processes when going to bed. Again, the strategies yield some benefit but ultimately offer little help. Danesha's work continues to suffer.

*Principle Used.* Desperate, Danesha seeks a second opinion from a sleep clinic at a hospital affiliated with the local university. A male clinician, a postdoctoral intern with a clinical psychology background, meets with her and asks about Danesha's sleep problems. He also asks about what else is going on in her life. Her work, tough and stressful, has really not ever given her much trouble. She typically thrives under pressure. So what now? The fuller story emerges through the dialogue with her new helper. Although she has been successful at climbing the career ladder, other parts of her life have been neglected. The crisis is existential, that is, it's about life and meaning. Nice things and money have not proved fulfilling. She thought that this is what she wanted.

The clinician also asks about her health. She has not had a physical in 2 years. A thyroid condition requires medication. But she only mentions her insomnia in passing. The clinician notes that thyroid issues can contribute to insomnia. They move on to talk about Danesha's life and what she wished were different. She brings up the possibility of doing some volunteer work. "Why not give it a try," is the clinician's response. He believes that moving from talking to doing is critical. It might help her "get out of herself." It might provide some meaning and help her feel less "self-absorbed" and "money centric." She returns several weeks later and discusses how volunteering has changed her feelings about herself and her life. She feels alive when giving to others and doing something that aligns with the values, which have been sidelined by her ambition.

In the end, Danesha changed jobs, using her executive skills to run a not-for-profit organization. The insomnia disappeared even though she and her helper never talked about how to resolve her sleep issues. She did get a physical and learned that her thyroid condition did require a medication adjustment.



The clinician at the sleep clinic was certainly concerned about Danesha's sleep. After all, he worked at a sleep clinic! However, his experience taught him that many things could contribute to sleep issues. He took the time to learn about Danesha and soon discovered that her personal and work life were at odds. Her sleep difficulty was just a symptom of other concerns.

It is easy to see the parallels between the concerns of Alisa and Danesha. Both came for a specific issue, but had helpers who took the time to help their clients find the real story and then the right story.

### ***Focus on a problem for which the benefits will outweigh the costs***

This is not an excuse for not tackling difficult problems, but it is a call for balance. If you demand a great deal of work from both yourself and the client, then the expectation is that there will be some kind of reasonable payoff for both of you.

*Principle Violated.* Margaret discovers to her horror that her husband Hector is HIV-positive. Tests reveal that she and her recently born son have not contracted the disease. This helps cushion the shock. But she has difficulty with her relationship with Hector. He claims that he picked up the virus from a "dirty needle." But she didn't even know that he had ever used drugs. The counselor focuses on the need for the "reconstruction of the marital relationship." He tells her that some of this would be painful because it would mean looking at areas of their lives that they had never reviewed or discussed. But Margaret is looking for some practical help in reorienting herself to her husband and to family life. After two sessions, she decides to stop coming.

*Principle Used.* Margaret still searches for help. The doctor who is treating Hector suggests a self-help group for spouses, children, and partners of HIV-positive patients. In the sessions, Margaret learns a great deal about how to relate to someone who is HIV-positive. The meetings are very practical. The fact that Hector is not in the group helps. She begins to understand herself and her needs better. In the security of the group, she explores mistakes she has made in relating to Hector. Although she does not "reconstruct" either her relationship with Hector or her own personality, she does learn how to live more creatively with both herself and her husband. She realizes that there will probably be further anguish, but she also sees that she is getting better prepared to face that future.

Reconstructing both relationships and personality, even if possible, is a very costly and chancy proposition. The cost-benefit ratio is out of balance. Once more it may be a question of a helper more committed to his or her theories than the needs of clients. Margaret gets the help she needs from the group and from sessions she and Hector have with a psychiatric aide. The value or value-seeking mind-set that pervades these principles is second nature in effective helpers. Box 9.2 lists some questions you can help clients ask themselves with an aim to adding value by working on the right things.

### **Use Self-Challenge to Help Clients Make the Right Decisions**

Remember that helping is rich in decision-making. Task I-C is not just about choosing the right things to work on. It highlights the importance of both helper and client making the right decisions at every step of the helping process. For clients Task I-C means initially choosing which issues to work on. Alisa, with Rena's help, decides that working directly on the depression and anxiety arising from her latest romantic relationship makes no sense. In fact, she decides

**BOX 9.2 Help Clients Do the Right Things**

Here are some questions related to the search for value that counselors can help clients ask themselves.

- What problem or opportunity should I really be working on?
- Which issue, if faced, would make a substantial difference in my life?
- Which problem or opportunity has the greatest payoff value?
- Which issue do I have both the will and the courage to work on?
- Which problem, if managed, will take care of other problems?
- Which opportunity, if developed, will help me deal with critical problems?
- What is the best place for me to start?
- If I need to start slowly, where should I start?
- If I need a boost or a quick win, which problem or opportunity should I work on?

that take mainly an opportunities approach in counseling. Focusing on career development and improving her health are most likely the answer, or at least part of the answer, to her depression and anxiety. Working on these two issues has value for her. Indeed, value is a cardinal word in therapy. The wider use of Task I-C revolves around value.

The word “right” as in “right story” is important. The entire helping process is a search for value for clients. You can help them ask themselves “right”-related questions throughout: “Am I working on the *right* issues? Am I setting the *right* goals? Have I drawn up the *right* plan for accomplishing these goals? Am I implementing my plan in the *right* way?” “Right” here means what is right for the client, not what fits the helper’s theories or preferred approach to treatment: “Does it fit me, my resources, my personal culture, the environment in which I live?” Clients are the decision makers, but you can and sometimes should invite them to consider the implications, including unintended consequences, of the decisions they are making.

So the spirit of I-C moves beyond the client’s choosing the right things to work on. In its fullness it contributes to clients’ search for meaning. “Meaning” is one of those words. In the sense that it is being used here it has no basis in science, at least in a narrow understanding of science. When a client says that her life is “meaningless,” we know instinctively what she means even if we know little about the specifics. Stories in the therapeutic encounter are often enough about the lack of meaning, even though the specifics differ from client to client. Things have meaning to the degree that they relate to values. So the beliefs-values-norms-ethics-morality package permeates the helping process even though the makeup of this package differs from client to client.

The spirit of I-B and I-C permeates the whole of the helping process and involves decision-making based on clients’ beliefs and values. In their core, B and C are both invitations to self-challenge and a search for value. The principle for the helper is this: In every stage and every task collaborate with the client and enlist his or her collaboration in adding value and making a difference—focusing

on issues that make a difference, engaging in substantive self-challenge, setting goals that make a difference, coming to grips with commitment to these goals, making plans that go somewhere, and engaging in life-enhancing change in everyday life. If you and your client are dabbling in change, then reset the system or forget the whole thing. Box 9.3 provides some broad guidelines for helping your clients get the most value out of therapy.

### **BOX 9.3** Guidelines for Stage I

#### **Establish a Working Alliance**

- Develop a collaborative working relationship with the client.
- Describe the process in language that the client can easily understand.
- Use the relationship as a vehicle for social-emotional reeducation.
- Do not do for clients what they can do for themselves. Keep the client in the driver's seat.

#### **Help Clients Tell Their Stories**

- Use a mix of tuning in, listening, empathy, probing, and summarizing, to help clients tell their stories, share their points of view, discuss their decisions, and talk through what they want to do as concretely as possible.
- Help clients talk productively about the past.
- Use probes when clients get stuck, wander about, or lack clarity.
- Understand blocks to client self-disclosure and providing support for clients having difficulty talking about themselves.
- Invite clients to reframe their stories and develop new perspectives.
- Determine clients' willingness to engage in self-challenge.

#### **Build Ongoing Client Assessment into the Helping Process**

- Get an initial feel for the severity of the client's problems and their ability to handle them.
- Note client resources, especially unused resources, and help the client work with these resources.
- Understand clients' problems and opportunities in the larger context of their lives.

#### **Help Clients Move to Action**

- Help clients develop an action orientation.
- Help clients spot early opportunities for changing self-defeating behavior or engaging in opportunity-development behavior.
- Find innovative forms of homework to help clients engage in problem-managing action in their everyday lives.

#### **Establish a Feedback and Evaluation System**

- Integrate feedback and evaluation into the helping process.
- Find ways of getting clients to participate in and own the evaluation process.
- Keep an evaluative eye on the entire process with the goal of adding value through each interaction and making each session better.

Most therapy engagements are relatively short term—say, six to ten sessions. A lot can be accomplished in that period of time, especially if therapy is designed to help clients “push start” themselves toward more productive or life-enhancing ways of thinking, behaving, dealing with emotions, and coping with negative experiences. When our clients leave us, they should be managing their problem situations more effectively or be well on their way. There is also some evidence that longer-term therapy can, in some cases, add even more value.

## Start Early with Links to Action LO 9.5

Linking the problem-management process to action should start early in the helping process. Early gains are a sign that therapy is headed in the right direction and will be successful. Also, we typically have limited time with our clients. For example, the modal number of sessions attended in community mental health centers is one and the median is five (Connolly Gibbons et al., 2011). Whatever the number currently is, time is still short. Helping clients connect what they learn from their work in tasks A, B, and C to the Action Arrow is critical. Right from the beginning, help clients act on what they are learning. Consider this case.

Samaira, an always-on-the-go marathoner, successful nurse practitioner, and mother of three active teenage children who are part of a bustling, fun, sometimes chaotic household, has just learned that she has early onset Parkinson's disease, a progressive and unpredictable disorder. Her world has collapsed; life has been turned upside down and inside out by this surreal news. Sobbing at work, she blurts out to a colleague, “I don't know what I am going to do. My life as I know it is over! I just want to run away and hide. How can I possibly do everything?” Her colleague, Kevin, a fellow nurse practitioner in the cardiology clinic, listens thoughtfully to Samaira express her grief. He, too, is in shock. He is very fond of Samaira and thinks of her as “Superwoman.” She is a take-charge, energetic, brilliant clinician who always seems to bring stability to tough situations. This is the first time he has seen her so upset. Yet, he recognizes that his colleague needs to express her grief and frustration. He knows that there are a host of complex, intricate emotions and issues that will have to be sorted through before Samaira can come to grips with this news and move forward with her life. This certainly won't be resolved in a brief, early morning talk in the clinic locker room.

After listening for a period, and offering understanding and compassion, Kevin again acknowledges her pain with an empathic statement and gently says, “I can't imagine how hard this must be for you. I feel overwhelmed.” Samaira says, “I still don't even know what this really means.” He responds, “You must be asking yourself, ‘Where do I start?’” His empathy provides her with an opening to talk about action even in the midst of her pain. Samaira says with a weak smile through her tears, “I guess after feeling sorry for myself, I need to work my network and learn what I am dealing with here.”

Listening linked to action is part of this interaction. A simple empathic comment about where to start leads to a commitment to action on Samaira's part. Kevin does not try to minimize her pain by saying something like, “You are going to be okay: you are the toughest person I know.” Nor does he offer fast solutions, “Dr. Craig specializes in Parkinson's, I bet he would be a good person to talk to.” Those may be good statements but not right now. Kevin will be there to help in the long run and can offer encouragement and advice as needed.

# Stage II: Help Clients Design and Set Problem-Managing Goals

## LEARNING OBJECTIVES

- 10.1 Help Clients Determine What Kind of Change They Need or Want**
  - Help Clients Distinguish Needs from Wants
  - Understand the Continuum between First-Order and Second-Order Change
- 10.2 Master the Art of Setting and Accomplishing Goals**
  - Recognize the Power of Goal Setting
  - Remember That Therapy Is Both Science and Art
  - Appreciate the Role of Hope in Therapy
  - Become Competent in the Three Tasks of Stage II
- 10.3 II-A: Help Clients Discover Possibilities for a Better Future**
  - Help Clients Focus on Their “Possible Selves”
  - Help Clients Tap into Their Creativity
  - Help Clients Engage in Divergent Thinking
  - Use Brainstorming Adaptively
  - Use Future-Oriented Probes
  - Help Clients Review Exemplars and Role Models as a Source of Possibilities
  - Review the Case of Brendan: Dying Better
- 10.4 II-B: Use Flexible Guidelines to Help Client Set Goals**
  - Help Clients Describe the Future They Want in Outcome Language
  - Help Clients Move from Broad Aims to Clear and Specific Goals
  - Help Clients Establish Goals That Make a Difference
  - Help Client Formulate Realistic Goals
  - Help Clients Set Prudent Goals
  - Help Clients Set Sustainable Goals
  - Help Clients Choose Flexible Goals
  - Help Clients Choose Goals Consistent with Their Values
  - Help Clients Establish Realistic Time Frames for Accomplishing Goals
  - Remember That Goals Can Emerge
- 10.5 II-C: Help Clients Commit Themselves to Their Goals**
- 10.6 See the Tasks of Stage II as Triggers for Action**
- 10.7 Explore the Shadow Side of Goal Setting**

## Help Clients Determine What Kind of Change They Need or Want **LO 10.1**

Therapy should be client driven. The degree of change sought is in the client's hands. While focusing on trivial issues and insignificant life changes is to be avoided, a complete personality makeover is an unrealistic goal. But consider Charles Colson, President Nixon's "hatchet man," sent to jail in 1974 for obstructing justice. He converted to Christianity and changed his life radically. When he died in 2012 he had written some 30 books; received 15 honorary doctorates for his non profit work in prison ministry, prisoner rehabilitation, and prison reform; had been given the Templeton Prize for an "exceptional contribution to affirming life's spiritual dimension"; and was awarded the Presidential Citizens Medal. It seems that Colson was high on the list of "100 percenters," people who give their all to any task they undertake. Most change falls somewhere between a teenager's upset over a lost girlfriend and the Colsons of the world. This is not to belittle the teenager's agony. But there are goals and there are **goals**. Some are part of daily life and some deserve the title "stretch" goals.

### Help Clients Distinguish Needs from Wants

In answering the question "How much change do clients need?" perhaps we need to ask another: "What kind of change does the client need?" In some cases, what clients want and what they need coincide. The lonely person wants a better social life and needs some kind of community to live a more engaging human life. In other cases, what clients want differs from what they need. Goal setting should focus on the package of needs and wants that makes sense for this particular client. Discrepancies must be worked out with the client. Consider the case of Irv.

Irv, a 41-year-old entrepreneur, collapsed one day at work. He had not had a physical in years. He was shocked to learn that he had both a mild heart condition and multiple sclerosis. His future was uncertain. The father of one of his wife's friends had multiple sclerosis but had lived and worked well into his 70s. But no one knew what the course of the disease would be. Because he had made his living by developing and then selling small businesses, he wanted to continue to do this, but it was too physically demanding. What he needed was a less physically demanding work schedule. Working 60–70 hours per week, even though he loved it, was no longer in the cards. Furthermore, he had always plowed the money he received from selling one business into starting up another. But now he needed to think of the future financial well-being of his wife and three children. Up to this point, his philosophy had been that the future would take care of itself. It was very wrenching for him to move from a lifestyle he wanted to one he needed.

Involuntary clients often need to be challenged to look beyond their wants to their needs. One woman who voluntarily led a homeless life was attacked and severely beaten on the street. But she still wanted the freedom that came with her lifestyle. When challenged to consider the kinds of freedom she wanted, she admitted that freedom from responsibility was at the core. "I want to do what I want to do when I want to do it." It was her choice to live the way she wanted. The counselor helped her explore the consequences of her choices and tried to

help her look at other options. How could she be “free” and not at risk? Was there some kind of trade-off between what she wanted and what she needed? In the end, of course, the decision was hers.

In the following case, the client, dogged by depression, was ultimately able to integrate what he wanted with what he needed.

Milos had come to the United States as a political refugee. The last few months in his native land had been terrifying. He had been jailed and beaten. He got out just before another crackdown. Once the initial euphoria of having escaped had subsided, he spent months feeling confused and disorganized. He tried to live as he had in his own country, but the North American culture was too invasive. He thought he should feel grateful, and yet he felt hostile. After 2 years of misery, he began seeing a counselor. He had resisted getting help because “back home” he had been “his own man.”

In discussing these issues with a counselor, it gradually dawned on him that he wanted to reestablish links with his native land but that he needed to integrate himself into the life of his host country. He saw that the accomplishment of both these broad aims would be very freeing. He began finding out how other immigrants who had been here longer than he had accomplished this goal. He spent time in the immigrant community, which differed from the refugee community. In the immigrant community, there was a long history of keeping links to the homeland culture alive. But the immigrants had also adapted to their adopted country in practical ways that made sense to them. The friends he made became role models for him. The more active he became in the immigrant community, the more his depression lifted.

In this case, goals responded to a mixture of needs and wants. If Milos had focused only on one or the other, he would have remained unhappy.

### Understand the Continuum between First-Order and Second-Order Change

First-order and second-order change are terms usually used when talking about organization or institutional change. **First-order change** is operational, while **second-order change** tends to be strategic. But the distinction relates in important ways to goal setting in therapy. Singhal, Rao, and Pant (2006) highlight the differences between first-order and second-order change as follows:

- Adjustments to the current situation versus changing the underlying system
- Motoring on as well as possible versus creating something new
- Change that might prove temporary versus change that is designed to endure
- Shoring up or fixing versus transforming
- Changed based on old learning or no learning versus changed based on new learning
- Change driven by the current set of values and behaviors versus change driven by a fundamental shift in values and behaviors
- The persistence of an old narrative versus the creation of a new narrative
- Fiddling with symptoms versus attacking causes

Given these characteristics, it is not surprising that in much of the literature, second-order change is seen, not just as a form of substantial change, but also as “good” or “real” change. First-order change is seen as the “little brother” of



second-order change. Second-order change means rolling up our sleeves and resetting the system, while first-order change means tinkering or coping with the system. Second-order change deals with causes, while first-order change deals with symptoms. Second-order change resolves the problem, while first-order change leaves the underlying problem in place and deals mostly with the easily seen manifestations of the problem.

However, I do not think things are that simple. It might be more useful to see change as a continuum with minor change (first-order change) at one end and major change (second-order change) at the other. First-order change has its uses. Sometimes it is the only kind of change possible. Consider this case.

Algis and Rodaina have been married for almost five years. He is 42-years-old. She is 31-years-old. He is the son of Lithuanian immigrants. She emigrated from Palestine. They are both nominally Catholic, but come from quite different Catholic traditions. Both work. They have no children even though they have always “intended” to. They find themselves constantly squabbling more and more over a range of issues, some important, many relatively trivial. These constant squabbles are undermining their relationship. Every once in a while it all erupts into a very nasty argument. They are headed for deeper trouble.

During a session with their pastor, he suggests that they should begin to think seriously about having a child. “You’ve become too preoccupied with yourselves and your differences. A child will change everything. It will help you get out of yourselves. Love will take the place of strife.” He urges them to see a marriage counselor.

They do spend a few, at times stormy, sessions with a marriage counselor. He tries to help them talk with one another more constructively. He teaches them listening and responding skills. He coaches them on how to discuss their grievances with each other fairly and decently. He helps them engage in problem solving around key problems such as finances. There is some progress, but it is inconsistent—one step forward, one step backwards, one step sideways. The prognosis does not look good. Eventually they stop seeing him. “We’re getting nowhere anyway.”

Let us skip what their pastor said for the moment. Looking at their sessions with the counselor, we can ask ourselves the following questions:

- Were Algis and Rodaina making adjustments to their current situation or were they trying to reset or reinvent their relationship?
- Were they trying to motor on the best they could or were they trying to create something new?
- Were the changes they were making likely to be lasting or were they still in danger of falling back into their old ways?
- Were they striving for incremental improvement or transforming their relationship?
- Were they learning small steps toward making their relationship work or were they learning what a renewed relationship would look like?
- Was their usual set of values and behaviors still in place or were they working toward a fundamental shift in their values and behaviors?
- Were they creating a new “narrative” or was the old narrative still in place?
- Were they fiddling with symptoms or dealing with causes?

Helping Algis and Rodaina reduce the frequency and the intensity of their squabbling smacks of first-order change. Helping them take a good look at

their current relationship and changing the style and terms of that relationship is closer to second-order change. But it is up to them, with the help of their counselor, to ask themselves the kind of questions listed above and make their own choices.

Choosing an adaptive, rather than a stretch, goal has been associated with coping (Coyne & Racioppo, 2000; Folkman & Moskowitz, 2000; Lazarus, 2000; Snyder, 1999). All human beings cope rather than conquer at times. In fact, in human affairs as a whole, coping probably outstrips conquering. And sometimes people have no other choice. It's cope or succumb. For some, coping has a bad reputation because it seems to be associated with mediocrity. But in many difficult situations helping clients cope is one of the best things helpers can do.

Coping, although a form of first-order change, often has an enormous upside. A young mother with three children has just lost her husband. Someone asks, "How's she doing?" The response, "She's coping quite well." She's not letting her grief get the better of her. She is taking care of the children and helping them deal with their sense of loss. She's moving along on all the tasks that a death in a family entails. At this stage, what could be more positive than that? Often therapy means healing clients cope.

So how much or what kind of change do clients need? It depends. They are in the driver's seat. They must make the decisions. The more you know about the ins and outs of goal setting and change, the more capable you are of helping them make the life-enhancing decisions that suit them.

## Master the Art of Setting and Accomplishing Goals LO 10.2

In many ways Stages II and III together with the Action Arrow are the most important parts of the helping model because they are about **problem-managing outcomes** in an approach to helping that is client-directed and outcome-informed (CDOI). It is here that counselors help clients develop and implement programs for constructive change. In Stages II and III, counselors help clients ask and answer the following two commonsense but critical questions: "What outcomes do I want?" and "What do I have to do to get them?" This chapter deals with the first question. Chapter 11 focuses on the second.

### Recognize the Power of Goal Setting

Goal setting, whether it is called that or not, is part of everyday life. We all do it all the time.

Why do we formulate goals? Well, if we didn't have goals, we wouldn't do anything. No one cooks a meal, reads a book, or writes a letter without having a reason, or several reasons, for doing so. We want to get something we want through our actions or we want to prevent or avoid something we do not want. These desires are beacons for our actions; they tell us which way to go. When formalized into goals, they play an important role in problem solving. (Dorner, 1996, p. 49)

Even not setting goals is a form of goal setting. If we do not name our goals that does not mean that we do not have any. Instead of overt goals, then, we have a set of covert goals. These are our default goals. They may be enhancing or limiting. We do not like the sagging muscles and flab we see in the mirror. But not

deciding to get into better shape is a decision to continue to allow the fitness program to drift.

Because life is filled with goals—chosen goals or goals by default—it makes sense to make them work for us rather than against us. Goals at their best mobilize our resources; they get us moving. They are a critical part of the self-regulation system. If they are the right goals for us, they get us headed in the right direction. There is a massive amount of sophisticated theory and research on goals and goal setting (Karoly, 1999; Locke & Latham, 1984, 1990, 2002). In their 2002 American Psychologist article, Locke and Latham summarize 35 years of empirical research on goal setting. According to this research, helping clients set goals empowers them in the following four ways.

***Goals help clients focus their attention*** A counselor at a refugee center in London described Simon, a victim of torture in a Middle Eastern country, to her supervisor as aimless and minimally cooperative in exploring the meaning of his brutal experience. Her supervisor suggested that she help Simon explore possibilities for a better future instead of focusing on the hell he had gone through. The counselor started one session by asking, “Simon, if you could have one thing you do not have, what would it be?” Simon response was immediate. “A friend,” he said. During the rest of the session, he was totally focused. What was uppermost in his mind was not the torture but the fact that he was so lonely in a foreign country. When he did talk about the torture, it was to express his fear that torture had “disfigured” him, if not physically, then psychologically, thus making him unattractive to others.

***Goals help clients mobilize their energy and direct their effort*** Clients who seem lethargic during the problem-exploration phase often come to life when asked to discuss possibilities for a better future. A patient in a long-term rehabilitation program who had been listless and uncooperative said to her counselor after a visit from her minister, “I’ve decided that God and God’s creation and not pain will be the center of my life. This is what I want.” That was the beginning of a new commitment to the arduous program. She collaborated more fully in doing exercises that helped her manage her pain. Clients with goals are less likely to engage in aimless behavior. Goal setting is not just a “head” exercise. Many clients begin engaging in constructive change after setting even broad or rudimentary goals.

***Goals provide incentives for clients to search for strategies to accomplish them*** Setting goals, a Stage II task, leads naturally into a search for means to accomplish them, a Stage III task. Lonnie, a woman in her 70s who had been described by her friends as “going downhill fast,” decided, after a heart-problem scare that proved to be a false alarm, that she wanted to, as she put it, “begin living again.” She said that the things that scared her most about almost meeting “Mr. Death” was that she felt that she had already died. But now her “resurrection” served as an incentive to live more fully. She said, “This time I’m going to live until I really die!”

***Clear and specific goals help clients persist*** Not only are clients with clear and specific goals energized to do something, but they also tend to work harder

and longer. An AIDS patient who said that he wanted to be reintegrated into his extended family managed, against all odds, to recover from five hospitalizations to achieve what he wanted. He did everything he could to buy the time he needed. Clients with clear and realistic goals do not give up as easily as clients with vague goals or with no goals at all.

One study (Payne, Robbins, & Dougherty, 1991) showed that high-goal-directed retirees were more outgoing, involved, resourceful, and persistent in their social settings than low-goal-directed retirees. The latter were more self-critical, dissatisfied, sulky, and self-centered. People with a sense of direction do not waste time in wishful thinking. Rather, they translate wishes into specific outcomes toward which they can work. Picture a continuum. At one end is the aimless person; at the other, there is a person with a keen sense of direction. Your clients may come from any point on the continuum. Taz knows that he wants to become a better supervisor but needs help in developing a program to do just that. On the other hand, Lola, one of Taz's colleagues, doesn't even know whether this is the right job for her and does little to explore other possibilities. Any given client may be at different points with respect to different issues—for instance, mature in seizing opportunities for education but aimless in developing sexual maturity. Most of us have had directionless periods in one area of life or another at one time or another.

### **Remember That Therapy Is Both Art and Science**

The answer to the question “Is therapy an art or a science?” is “Yes.” It is a product of the social sciences (not the “hard” sciences such as physics or chemistry, so it is imperative that therapists adapt and tailor its research findings to the needs of clients. Therapists with a design-thinking mentality help clients design rather than set goals. They help clients design their future. Design is usually associated with the arts. But, as we have seen, there is a movement to incorporate “design thinking” into problem management (Ambrose & Harris, 2010; Lockwood, 2010) or vice versa. Ill-defined problems constitute the starting point of design thinking which moves on to acquiring a deeper understanding of the context of the problem. This kind of thinking highlights creativity in the search for insights and solutions. Design thinking often starts with the goal, and then moves between the present and the future in the search for creative solutions. The ultimate challenge is to fit the solution to the context.

As you can see, much of design thinking sounds like some of the main themes of the *art* of problem management. Therapy needs to be both rigorous and soft-edged. There is both art and science in what we do. There is an art to helping clients explore possibilities for a better future before nailing down one possibility or a particular set. While a lot of the books on design thinking are focused on business (Merholz, Wilkens, Schauer, & Verba, 2008), they still provide the principles underlying such thinking. Stanford offers a Design Thinking Boot Camp that is associated with its business school. There are a number of design-thinking programs for higher education and for educators in general (Bell, 2010). IDEO, a global design firm, relates design thinking to creating a more desirable future in the face of difficult challenges. Sounds like Stage II of the problem-management process. Some see design thinking as nonsense, perhaps because of the way it

mixes art and reason, but I see it as a softer-edged contribution to the helping professions that can help produce hard-edged results.

### **Appreciate the Role of Hope in Therapy**

Stage II is about yet-to-be-realized outcomes. It's about the future. And so **hope**, another soft-edged concept or experience that can have a hard-edged impact on therapeutic outcomes, is involved. Hope, as part of human experience, is as old as humanity. Who of us has not started sentences with "I hope . . ."? Hope plays a key role in both developing and implementing possibilities for a better future. An Internet search reveals that scientific psychology has not always been interested in hope (R. S. Lazarus, 1999; Stotland, 1969). But our clients are.

Rick Snyder, who, as we have seen earlier, has written extensively about the positive and negative uses of excuses in everyday life (Snyder & Higgins, 1988; Snyder, Higgins, & Stucky, 1983), became a kind of champion for hope (1994, 1995, 1997, 1998; McDermott & Snyder, 1999; Snyder, McDermott, Cook, & Rapoff, 1997; Snyder, Michael, & Cheavens, 1999). Indeed, he linked excuses and hope in an article entitled "Reality negotiation: From excuses to hope and beyond" (1989). He died in 2006 and the encomiums he received at the time of his death from his colleagues at the University of Kansas indicated how well he lived what he preached.

In psychological terms hope in therapy is sometimes called "expectancy." Or, because expectancies can be positive, neutral, or negative, the term "positive-outcome expectancy bias" is used. There is plenty of evidence to show that clients who expect therapy outcomes to be positive have a better chance of achieving positive outcomes. At any rate, hope and expectancy can play an important role in therapy (Reiter, 2010; Westra, Constantino, & Aviram, 2011—an Internet search will give you dozens of articles).

Over the course of history there have been different takes on hope. But even in science there are positive views of hope and some research backing them up. Jerome Groopman (2004), who holds a chair of medicine at Harvard Medical School, in a very moving book on the anatomy of hope, defines it "as the elevating feeling we experience when we see—in the mind's eye—a path to a better future. Hope acknowledges the significant obstacles and deep pitfalls along that path. True hope has no room for delusion" (p. xiv). His search for a scientific basis for understanding the key role that hope plays in dealing with illness takes him to the "biology" of hope. His book also shows how counseling is at the heart of medical practice.

Snyder, on the other hand, started with the premise that human beings are goal directed and relates hope to the goal-setting process. According to Snyder, hope is the process of:

- Thinking about one's goals—for instance, Serena is determined that she will give up smoking, drinking, and soft drugs now that she is pregnant.
- Having the will, desire, or motivation to move toward these goals—Serena is serious about her goal because she has seen the damaged children of mothers on drugs, and she is also, at heart, a decent, caring person.

Hope is a dimension of the problem-management process. Serena is hopeful. If we say that Serena has "high hopes," we mean that her goal is clear, her sense of

agency (or urgency) is high, and that she is realistic in planning the pathways to her goal. Both a sense of agency and some clarity around pathways are required.

Hope, of course, has emotional connotations. But it is not a free-floating emotion. Rather, it is the by-product or outcome of the work of setting goals, developing a sense of agency, and devising pathways to the goal. Serena feels a mixture of positive emotions—elation, determination, satisfaction—knowing that “the will” (agency) and “the way” (pathways) have come together. Success is in sight even though she knows that there will be barriers—for instance, the ongoing lure of tobacco, wine, and soft drugs.

Snyder (1995, pp. 357–358) combed the research literature in order to discover the benefits of hope as he defines it. Here is what he found.

The advantages of elevated hope are many. Higher as compared with lower hope people have a greater number of goals, have more difficult goals, have success at achieving their goals, perceive their goals as challenges, have greater happiness and less distress, have superior coping skills, recover better from physical injury, and report less burnout at work, to name but a few advantages.

An article in the *Harvard Heart Letter* (August, 2008) highlights the benefits of hope but counsels balance: “Hope is a powerful force. It can sustain you through personal tragedy or can carry you through the dark tunnel of disease. A sense of realism matters, too, grounding hope before it flits into fantasy” (p. 2).

## Become Competent in the Three Tasks of Stage II

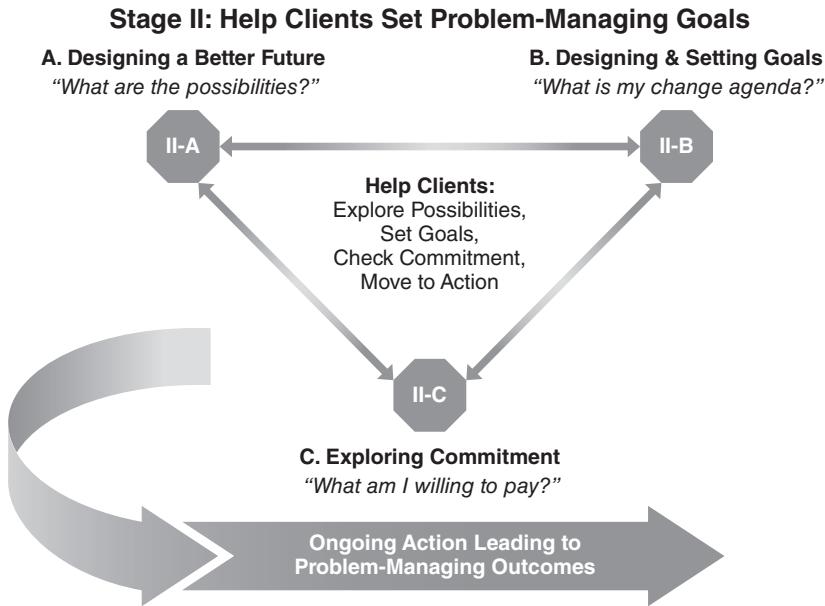
Stage II is about helping clients design a better future for themselves. As Gelatt (1989) noted, “The future does not exist and cannot be predicted. It must be imagined and invented” (p. 255). The interrelated tasks of Stage II (see Figure 10.1) outline three ways in which helpers can partner with their clients with a view to exploring, designing, and developing this better future. These three interrelated tasks are as follows:

- **Task II-A—Develop Problem-Managing Possibilities.** “What possibilities do I have for a better future?” “What are some of the things I think I want?” “What about my needs?” “What would my problem situation look like if it were being managed well?” In helping clients move from problems to solutions, counselors help them develop a sense of hope.
- **Task II-B—Choose Outcomes with Impact.** “What do I really want and need? What outcomes will manage my problem situation and/or help me develop some unused opportunity?” Here counselors help clients craft a viable change agenda from among the possibilities.
- **Task II-C—Demonstrate Commitment.** “What am I willing to pay for what I want?” Help clients discover incentives for the work needed to achieve these outcomes.

In actual counseling sessions, Stage I and Stage II are intermingled. Stories lead to the discovery of problem-managing goals, then there is often a return to the story and new perspectives emerge, and this leads to the modification of the goals. As noted in Chapter 8, clients engage in small or large actions that move this entire process forward.

A *goal* is some desired state. Clive, a young man in DUI trouble realized that an essential goal was to stop drinking. But a goal is just an idea until it is



**FIGURE 10.1**

The Three Tasks of Stage II

accomplished. An accomplished goal is an *outcome*, and, as we have seen therapy is about life-enhancing outcomes for clients. Clive, perhaps driven by the fear of jail time for one more DUI citation, joined AA, conscientiously followed the program, and stopped drinking—an essential outcome. But there is one more important factor or dimension. The outcome must have the desired *impact* on the client's life, that is, it must be a *problem-managing* outcome (or opportunity-developing outcome), which it was in Clive's case. He no longer had to fear another DUI citation as long as he avoided alcohol. In a sense we can say that Clive “solved” his problem. In many ways, outcomes are more important than actions through which they are achieved. Although Clive chose the AA program, he could have cut his addiction to alcohol in other ways.

Perhaps it is best to avoid the word “solution.” Mathematical problems have solutions, but problems in living need to be managed rather than solved. Moreover, when it comes to changing human behavior the term “solution” can mean two different things. An outcome with the desired impact is a solution with a big S—in Clive's case eliminating the alcohol habit. The actions leading to this outcome—his adherence to the AA program—constitute a solution with a small s. Programs that lead to outcomes are not outcomes themselves. They should not be confused. When facing a problem situation, some, perhaps many, clients try a variety of solutions-with-a-small-s, that is, action programs, until they find one that works. This may ultimately be effective, that is, the goal *is* accomplished, but some professionals say that this hit-and-miss process leading to the accomplishment is not very efficient. They contend that people do not tend to learn very much from this approach, but they keep trying it because “it works.”



Other professionals such as entrepreneurs (Chapter 3) and those who espouse design-thinking or action-learning approaches to change (Chapter 2) take a much different approach. They contend that an overly rigorous search for the “one right answer” is not only inefficient but also inhuman. Clients do not think this way. The messier approach, they say, provides many different kinds of learning. Messiness is more innovative. Your job is to use approaches that best fit the needs of your clients. Some will want rigor, others will benefit from a bit of messiness. You will need to adapt.

## II-A: Help Clients Discover Possibilities for a Better Future **LO 10.3**

The goal of Task II-A is to help clients develop a sense of direction by exploring *possibilities* for a better future. I once was sitting alone at the counter of a late-night diner when a young man sat down next to me even though all the other stools were empty. The conversation drifted to the problems he was having with a friend of his. I listened for a while and then asked, “Well, if your relationship was just what you wanted it to be, what would it look like?” It took him a bit of time to get started, but eventually he drew a picture of the kind of relationship he could live with. Then he stopped, looked at me, and said, “You must be a professional.” I believe he thought that I must be a professional because this was the first time in his life that anyone had ever asked him to describe some possibilities for a better future.

Reviewing possibilities for a better future often helps clients move beyond the problem-and-misery mind-set they bring with them and develop a sense of hope. It can also help clients understand their problem situations better—“Now that I am beginning to know what I want, I can see my problems and unused opportunities more clearly.” This is a common example of the intermingled nature of the task of the problem-management process.

Christine, a single woman in her mid-thirties, thought that getting the right career would be the most important thing in life. After receiving an MBA, she got an excellent job in an investment firm and advanced rapidly, doing better than any other woman in the firm. She was extremely busy; her life was full. At age 38, she met a very engaging married man and had an affair that lasted a year. The affair ended abruptly when his wife sued for divorce. Then everything collapsed for Christine. In her first session with a therapist she said that both her job and the affair were “meaningless.”

“Meaning” became the main theme of her five sessions over 15 weeks with the therapist. At times she despairingly argued that the word “meaning” was itself meaningless. But a life without meaning was worse. After all, her job and even her affair gave some kind of meaning to her life. “Or,” she would ask, “Did they just give me satisfaction? An ugly word!” At the beginning of one session, when the therapist asked for feedback on what had happened between sessions, Christine said, “Meaning is the real thing. Happiness is a byproduct.” They went on to discuss the kinds of things that would give “the right kind of meaning.” A new career, reconnecting with family, religion, politics, becoming a social entrepreneur, marriage, children all competed with one another in her review of meaning.

In the end, Christine discovered for herself that “getting out of myself and getting creatively involved with others is central to what I want. My whole me-centered

life has been a bust.” She continued to explore possibilities on her own and finally made the decision to become “her kind” of social entrepreneur.

Too many clients are locked in to the present. Even when they try to use their imaginations, they think incrementally. The future they envision is not much better than the present they dislike. Helping clients engage in some kind of “break away” thinking can be invaluable.

At its best, counseling helps clients move from problem-centered mode to “discovery” mode. Discovery mode involves creativity and divergent thinking. Do an Internet search on creativity and divergent thinking and you will be overwhelmed by the results. Dean Simonton (2000) reviewed advances in our understanding and use of creativity as part of positive psychology. According to Taylor, Pham, Rivkin, and Armor (1998), however, not just any kind of mental stimulation will do. Mental stimulation is helpful to the degree that it “provides a window on the future by enabling people to envision possibilities and develop plans for bringing those possibilities about. In moving oneself from a current situation toward an envisioned future one, the anticipation and management of emotions and the initiation and maintenance of problem-solving activities are fundamental tasks” (p. 429).

Your role in helping clients become more creative in their thinking about the future is an important, even essential. Uzzi and Spiro (2005) debunk the myth that creativity is the “brash work of loners” (p. 448). Their research shows that creative thinking and acting at it best it is a social enterprise. And therapy is just that, a social enterprise. Helping is a two-person collaborative exercise in creativity. You are truly a catalyst for the client’s elusive creative abilities.

If you ask a married couple, “If you are to stay married, what kind of marriage do you want? What would it look like?” Their answer is rooted in the marriage they have but do not want. They are being asked to move beyond the problem situation that they know only too well. They are being asked, to use Simonton’s phrase, to “harness the imagination.” Here are some ways to help clients to do precisely that.

### Help Clients Focus on Their “Possible Selves”

One of the characters in Gail Godwin’s (1984) novel *The Finishing School* warns against getting involved with people who have “congealed into their final selves.” Clients come to helpers, not necessarily because they have congealed into their final selves—if this is the case, why come at all?—but because they are stuck in their current selves. Counseling is a process of helping clients get “unstuck” and develop a sense of direction. Markus and Nurius used the term possible selves to represent “individuals’ ideas of what they might become, what they would like to become, and what they are afraid of becoming” (1986, p. 954). Over the years a great deal of interesting and clinically useful research has been done on the concept of “possible selves” (Bardach et al., 2010; Carroll, Shepperd, & Arkin, 2010; Cross & Markus, 1991, 1994; Eagly, Eastwick, & Johannesen-Schmidt, 2009; Meek, 2011; Oyserman, Bybee, & Hart-Johnson, 2004; Robinson, Davis, & Meara, 2003; Rossiter, 2007). Although we are using the term as a tool for helping clients imagine a better future for themselves, it is also possible that

clients come to us with very limiting or negative possible selves. Consider the case of Ernesto. He was very young but very stuck for a variety of sociocultural and emotional reasons.

A counselor first met Ernesto in the emergency room of a large urban hospital. He was throwing up blood into a pan. He was a member of a street gang, and this was the third time he had been beaten up in the last year. He had been so severely beaten this time that it was likely that he would suffer permanent physical damage. Ernesto's lifestyle was doing him in, but it was the only one he knew. No thought of any kind of upbeat possible self crossed his mind. He was in desperate need of a new way of living, a new scenario, and a new way of participating in city life. This time he was hurting enough to consider the possibility of some kind of change. The counselor worked with Ernesto, not by helping him explore the complex socio-cultural and emotional reasons he was in this fix, but principally by helping him explore some upbeat "possible selves" in order to discover a different purpose in life, a different direction, a different lifestyle.

"Possible selves encompass not only the goals we are seeking but all the imaginable futures we might occupy" (King & Hicks, 2007, p. 626). The term possible self, although psychologically respectable, has a flair to it that can capture clients' imaginations in a way that the term "goal" cannot.

### Help Clients Tap into Their Creativity

One of the myths of creativity is that some people are creative and others are not. All of us have some spark of creativity within us. So clients can be more creative than they are. It is a question of finding ways to help them be so. Of course, counselors cannot help clients be more creative unless they themselves are creative about the helping process itself. Carson and Becker (2004), in reviewing a group of articles in a special 2002 issue of the *Journal of Clinical Activities, Assignments, & Handouts in Psychotherapy Practice* (see Hecker & Kottler, 2002), suggest that "being able to access our own creativity at peak levels in an effort to help clients tap their own creative problem-solving abilities (internal and relational) and creative resources is a prerequisite to effective therapy" (p. 111). Clients, they say, should be a source of creativity for helpers and vice versa. Stages II and III help clients tap into their dormant creativity.

A review of the requirements for creativity (see Cole & Sarnoff, 1980; Robertshaw, Mecca, & Rerick, 1978, pp. 118–120) shows, by implication, that people in trouble often fail to use whatever creative resources they might have. The creative person is characterized by the following (rate yourself as you read through the list):

- *Optimism and confidence* (whereas clients are often depressed and feel powerless)
- *Acceptance of ambiguity and uncertainty* (whereas clients may feel tortured by ambiguity and uncertainty and want to escape from them as quickly as possible)
- *A wide range of interests* (whereas clients may be people with a narrow range of interests or whose normal interests have been severely narrowed by anxiety and pain)

- *Flexibility* (whereas clients may have become rigid in their approach to themselves, others, and the social settings of life)
- *Tolerance of complexity* (whereas clients are often confused and looking for simplicity and simple solutions)
- *Verbal fluency* (whereas clients are often unable to articulate their problems, much less their goals and ways of accomplishing them)
- *Curiosity* (whereas clients may not have developed a searching approach to life or may have been hurt by being too venturesome)
- *Drive and persistence* (whereas clients may be all too ready to give up)
- *Independence* (whereas clients may be quite dependent or counter dependent)
- *Nonconformity* or reasonable risk taking (whereas clients may have a history of being very conservative and conformist).

Of course some clients may be nonconformist but get into trouble because their particular “brand” of nonconformity does not sit well with others.

On the other hand, innovation is hindered by the following (see Azar, 1995):

- *Fear*—clients are often quite fearful and anxious.
- *Fixed habits*—clients may have self-defeating habits or patterns of behavior that may be deeply ingrained.
- *Dependence on authority*—clients may come to helpers looking for the “right answers” or be quite counter dependent (the other side of the dependence coin) and fight efforts to be helped.
- *Perfectionism*—clients may come to helpers precisely because they are hounded by this problem and can accept only ideal or perfect solutions.

### Help Clients Engage in Divergent Thinking

Many people habitually take a convergent-thinking approach to problem solving—that is, they look for the “one right answer” or the one that would be culturally acceptable. Such thinking has its uses, of course. Often enough there is a right answer. However, many of life’s problem situations are too complex to be handled by convergent thinking. Such thinking limits the ways in which people use their own and environmental resources.

Divergent thinking, on the other hand, assumes that there is always more than one answer. De Bono (1992) called it “lateral thinking.” It is related to curiosity, “a positive emotional-motivational system associated with the recognition, pursuit, and self-regulation of novelty and challenge” (Kashdan, Rose, & Fincham, 2004, p. 291). Consider the following case.

Quentin wanted to be a doctor, so he enrolled in the premed program at school. He did well but not well enough to get into medical school. When he received the last notice of refusal, he said to himself, “Well, that’s it for me and the world of medicine. Now what will I do?” When he graduated, he took a job in his brother-in-law’s business. He became a manager and did fairly well financially, but he never experienced much career satisfaction. He was glad that his marriage was good and his home life rewarding, because he derived little satisfaction from his work.

Not much divergent thinking went into handling this problem situation. No one asked Quentin what he really wanted. For Quentin, becoming a doctor was the

“one right career.” He did not give serious thought to any other career related to the field of medicine, even though there are dozens and dozens of interesting and challenging jobs in the field of health care.

The case of Caroline, who also wanted to become a doctor but failed to get into medical school, is quite different from that of Quentin.

Caroline thought to herself, “Medicine still interests me; I’d like to do something in the health field.” With the help of a medical career counselor, she reviewed the possibilities. Even though she was in premed, she had never realized that there were so many medical careers. She decided to take whatever courses and practicum experiences she needed to become a nurse. Then, while working in a clinic in the hills of Appalachia—an invaluable experience for her—she managed to get an M.A. in family-practice nursing by attending a nearby state university part time. She chose this specialty because she thought that it would enable her to be closely associated with delivery of a broad range of services to patients and would also enable her to have more responsibility for the delivery of these services.

When Caroline graduated, she entered private practice as a nurse practitioner with a doctor in a small Midwestern town. Because the doctor divided his time among three small clinics, Caroline had a great deal of responsibility in the clinic where she practiced. She also taught a course in family-practice nursing at a nearby state school and conducted workshops in holistic approaches to preventive medical self-care. Still not satisfied, she began and finished a doctoral program in practical nursing. She taught at a state university and continued her practice. Needless to say, her persistence paid off with an extremely high degree of career satisfaction. She became the dean of a state school of nursing.

Quentin’s case is probably the norm, not Caroline’s. For many, divergent thinking is either uncomfortable or too much work.

### Use Brainstorming Adaptively

One way of helping clients think divergently and more creatively is brainstorming. Brainstorming is a simple idea-stimulation technique for exploring the elements of complex situations. Brainstorming in Stages II and III is a tool for helping clients develop both possibilities for a better future and ways of making this future a reality.

There are certain rules that help make this technique work: suspend judgment, produce as many ideas as possible, use one idea as a takeoff point for others, get rid of normal constraints to thinking, and produce even more ideas by clarifying items on the list. Here, then, are the rules.

***Suspend your own judgment, and help clients suspend theirs*** When brainstorming, do not let clients criticize the ideas they are generating and, of course, do not criticize them yourself. There is some evidence that this rule is especially effective when the problem situation has been clarified and defined and goals have not yet been set. In the following example, a woman whose children are grown and married is looking for ways of putting meaning into her life.

**CLIENT:** One possibility is that I could become a volunteer, but the very word makes me sound a bit pathetic.

**HELPER:** Add it to the list. Remember, we’ll discuss and critique them later.

Having clients suspend judgment is one way of handling the tendency on the part of some to play a “Yes, but” game with themselves. That is, they come up with a good idea and then immediately show why it isn’t really a good idea, as in the preceding example. By the same token, avoid saying such things as “I like that idea,” “This one is useful,” “I’m not sure about that idea,” or “How would that work?” Premature approval and criticism cut down on creativity. A marriage counselor was helping a couple brainstorm possibilities for a better future. When Nina said, “We will stop bringing up past hurts,” Tip, her husband, replied, “That’s your major weapon when we fight. You’ll never be able to give that up.” The helper said, “Add it to the list. We’ll look at the realism of these possibilities later on.”

***Encourage clients to come up with a wide but focused range of possibilities***

The traditional principle is that quantity ultimately breeds quality. Some of the best ideas come along later in the brainstorming process. Cutting the process short can be self-defeating. In the following example, a man in a sex-addiction program has been brainstorming activities that might replace his preoccupation with sex.

**CLIENT:** Maybe that’s enough. We can start putting it all together.

**HELPER:** It doesn’t sound like you were running out of ideas.

**CLIENT:** I’m not. It’s actually fun. It’s almost liberating.

**HELPER:** Well, let’s keep on having fun for a while.

**CLIENT (pausing):** Ha! I could become a monk.

Later on, the counselor, focusing on this “possibility,” asked, “What would a modern-day monk who’s not even a Catholic look like?” This helped the client explore the concept of sexual responsibility from a completely different perspective and to rethink the place of religion and service to others in his life.

However, possibility generation is not an end in itself. Coyne, Clifford, and Dye (2007) challenge the quantity-breeds-quality rule, at least in terms of its efficiency. They suggest that *focused* brainstorming does a better job. In counseling that means the helper formulates questions relevant to the client’s problems or unused opportunities and then helps the client brainstorm around these more focused issues. When it comes to how extensive brainstorming should be, use your clinical judgment, your social intelligence, to determine when enough is enough. If a client wants to stop, often it’s best to stop.

***Help clients use one idea to stimulate others*** This is called piggybacking. Without criticizing the client’s productivity, encourage him or her both to develop strategies already generated and to combine different ideas to form new possibilities. In the following example, a client suffering from chronic pain is trying to come up with possibilities for a better future.

**CLIENT:** Well, if there is no way to get rid of all the pain, then I picture myself living a full life without pain at its center.

**HELPER:** Expand that a bit for me.



**CLIENT:** The papers are filled with stories of people who have been living with pain for years. When they're interviewed, most of them look miserable. They're like me. But every once in a while there is a story about someone who has learned how to live creatively with pain. Very often they are involved in some sort of cause that takes up their energies. They do not have time to be preoccupied with pain. When one client with multiple sclerosis brought of this possibility: "I'll have a friend or two with whom I can share my frustrations as they build up," the helper asked, "What would that look like?" The client replied, "Not just a complaining session or just a poor-me thing. It would be a normal part of a give-and-take relationship. We'd be sharing both joys and pain of our lives like other people do."

### ***Help clients let themselves go and develop some "wild" possibilities***

When clients seem to be "drying up" or when the possibilities being generated are quite pedestrian, you might say, "Okay, now draw a line under the items on your list and write the word wild under the line. Now let us see if you can come up with some really wild possibilities." Later it is easier to cut suggested possibilities down than to expand them. The wildest possibilities often have within them at least a kernel of an idea that will work. In the following example, an older single man who is lonely is exploring possibilities for a better future.

**CLIENT:** I can't think of anything else. And what I've come up with isn't very exciting.

**HELPER:** How about getting a bit wild? You know, some crazy possibilities.

**CLIENT:** Well, let me think. . . . I'd start a commune and would be living in it. . . . And. . . .

Clients often need permission to let themselves go even in harmless ways. They repress good ideas because they might sound foolish. Helpers need to create an atmosphere in which such apparently foolish ideas will be not only accepted but also encouraged. Help clients come up with conservative possibilities, liberal possibilities, radical possibilities, and even outrageous possibilities.

That said, brainstorming might not be your client's cup of tea, or your cup of tea. It's not always necessary or even advisable to use brainstorming explicitly. As helper, you can keep these rules—which themselves are not set in stone—in mind and then by sharing highlights and using probes, you can get clients to brainstorm even though they do not know that's what they're doing. A brainstorming mentality, not its ritualistic practice, is useful throughout the helping process.

### **Use Future-Oriented Probes**

One way of helping clients invent the future is to ask them, or get them to ask themselves, future-oriented questions related to their current unmanaged problems or undeveloped opportunities. The following questions are different ways of helping clients find answers to the questions "What do you want?" and "What do you need?"



- **What would this problem situation look like if you were managing it better?** Ken, a college student who has been a “loner,” has been talking about his general dissatisfaction with his life. In response to this question, he said, “I’d be having fewer anxiety attacks. And I’d be spending more time with people rather than by myself.”
- **What changes in your present lifestyle would make sense?** Cindy, who described herself as a “bored homemaker,” replied, “I would not be drinking as much. I’d be getting more exercise. I would not sit around and watch the soaps all day. I’d have something meaningful to do.”
- **What would you be doing differently with the people in your life?** Lon, a graduate student at a university near his parents’ home, realized that he had not yet developed the kind of autonomy suited to his age. He mentioned these possibilities: “I would not be letting my mother make my decisions for me. I’d be sharing an apartment with one or two friends.”
- **What current patterns of behavior would be eliminated?** Bridget, a resident in a nursing home, added these to her list, “I would not be putting myself down for incontinence I cannot control. I would not be complaining all the time. It gets me and everyone else down!”
- **What would you have that you do not have now?** Sissy, a single woman who has lived in a housing project for 11 years, said, “I’d have a place to live that’s not rat-infested. I’d have some friends. I wouldn’t be so miserable all the time.” Drew, a man tortured by perfectionism, mused, “I’d be wearing sloppy clothes, at least at times, and like it. More than that, I’d have a more realistic sense of the world and my place in it. The world is messy; it’s chaotic much of the time. I’d find the beauty in the chaos.”
- **What accomplishments would be in place that are not in place now?** Ryan, a divorced man in his mid-30s, said, “I’d have my degree in practical nursing. I’d be doing some part-time teaching. I’d be close to someone that I’d like to marry.”
- **What would an unused opportunity look like if you were to develop it?** Enid, a woman with a great deal of talent who has been given one modest promotion in her company but who feels like a second-class citizen, had this to say: “In two years I’ll be an officer of this company or have a very good job in another firm.”

It is a mistake to suppose that clients will automatically gush with answers. Ask the kinds of questions just listed, or encourage them to ask themselves the questions, but then help them answer them.

### Help Clients Review Exemplars and Role Models as a Source of Possibilities

Some clients can see future possibilities better when they see them embodied in others. You can help clients brainstorm possibilities for a better future by helping them identify exemplars or models. By models, I do not mean superstars or people who do things perfectly. That would be self-defeating. In the next example, a marriage counselor is talking with a middle-aged, childless couple. They are bored with their marriage. When he asked them, “What would your marriage look like if it looked a little better?” he could see that they were stuck.

**COUNSELOR:** Maybe the question would be easier to answer if you reviewed some of your married relatives, friends, or acquaintances.

**WIFE:** None of them have super marriages. (Husband nods in agreement.)

**COUNSELOR:** No, I do not mean super marriages. It's about bits and pieces, smaller thing that you could put in your marriage that would make it a little better.

**WIFE:** Well, Fred and Lisa are not like us. They do not always have to be doing everything together.

**HUSBAND:** Who says we have to be doing everything together? I thought that was your idea.

**WIFE:** Well, we always are together. If we weren't always together, we wouldn't be in each other's hair all the time.

**COUNSELOR:** All right, who else do you know who are doing things in their marriage that appeal to you? Anyone.

**HUSBAND:** You know Ron and Carol do some volunteer work together. Ron was saying that it gets them out of themselves. I bet they have better conversations because of it.

Even though it was a somewhat torturous process, these two people were able to come up with a range of possibilities for a better marriage. The counselor had them write them down so they wouldn't lose them. At this point, the purpose was not to get the clients to commit themselves to these possibilities but to identify them.

In the following case, the client finds herself making discoveries by observing people she had not identified as models at all.

Fran, a somewhat withdrawn college junior, realizes that when it comes to interpersonal competence, she is not ready for the business world she intends to enter when she graduates. She wants to do something about her interpersonal style and a few nagging personal problems. She sees a counselor in the Office of Student Services. After a couple of discussions with him, she joins a "lifestyle" group on campus that includes some training in interpersonal skills. Even though she expands her horizons a bit from what the members of the group say about their experiences, behaviors, and feelings, she tells her counselor that she learns even more by watching her fellow group members in action. She sees behaviors that she would like to incorporate into her own style. A number of times she says to herself in the group, "Ah, there's something I never thought of." Without becoming a slavish imitator, she begins to incorporate some of the patterns she sees in others into her own style.

Models or exemplars can help clients name what they want more specifically. Models can be found anywhere: among the client's relatives, friends, and associates, in books, on television, in history, in movies. Counselors can help clients identify models, choose those dimensions of others that are relevant, and translate what they see into realistic possibilities for themselves.

### **Review the Case of Brendan: Dying Better**

Brendan, a heavy drinker, had extensive and irreversible liver damage, and it was clear that he was getting sicker. But he wanted to "get some things done" before he died. Brendan's action orientation helped a great deal. Over the course of a few

months, a counselor helped him to name some of the things he wanted before he died or on his journey toward death. Brendan in a homework exercise came up with the following possibilities:

- “I’d like to have some talks with someone who has a religious orientation, like a minister. I want to discuss some of the ‘bigger’ issues of life and death.”
- “I don’t want to die hopeless. I want to die with a sense of meaning.”
- “I want to belong. You know, to some kind of community, people who know what I’m going through, but who are not sentimental about it. People not disgusted with me because of the way I’ve done myself in.”
- “I’d like to get rid of some of my financial worries.”
- “I’d like a couple of close friends with whom I could share the ups and downs of daily life. With no apologies.”
- “As long as possible, I’d like to be doing some kind of productive work, whether paid or not. I’ve been a flake. I want to contribute even if just in an ordinary way.”
- “I need a decent place to live, maybe with others.”
- “I need decent medical attention. I’d like a doctor who has some compassion; one who could challenge me to live until I die.”
- “I need to manage these bouts of anxiety and depression better.”
- “I want to get back with my family again. I want to hug my dad. I want him to hug me.”
- “I’d like to make peace with one or two of my closest friends. They more or less dropped me when I got sick. But at heart, they’re good guys.”
- “I want to die in my hometown.”

Of course, Brendan did not name all these possibilities at once. Through empathy and probes, the counselor helped Brendan name what he needed and wanted and then helped him stitch together a set of goals from these possibilities (Stage II) and ways of accomplishing them (Stage III).

## II-B: Use Flexible Guidelines to Help Clients Set Goals **LO 10.4**

Practical goals do not usually leap out fully formed. They need to be shaped or designed. Effective counselors add value by engaging clients in the kind of dialogue that will help them design, choose, craft, shape, and develop their goals. Goals are specific statements about what clients want and need. The goals that emerge through this client-helper dialogue are more likely to be workable if they have, for the most part, the following characteristics. They need to be stated as outcomes; specific enough to be verifiable; substantially related to the problem situation; venturesome and prudent; realistic; sustainable; reasonably flexible; congruent with the client’s values; and set in a reasonable time frame.

Just how this package of goal characteristics will look in practice will differ from client to client. There is no one formula. From a practical point of view, these characteristics can be seen as “tools” that counselors can use to help clients

design and shape or reshape their goals. In general, goals with these characteristics are more likely to be turned into problem-managing outcomes with the desired impact on clients' lives. If you listen carefully to clients, they will provide hints or clues or cues as to when any given principle might help. These principles are not a step-by-step program. Ineffective helpers will get lost in the details of these characteristics. Some might say, "Clients do not need all this," and they would be right. Helpers need to understand the anatomy of goal setting and decision making in order to be able to respond to any given client need. Effective helpers will keep these principles in the back of their minds and, in a second-nature manner, turn them into helpful "sculpting" probes at the right time. The characteristics of fully shaped goals listed above take on life through the following flexible principles.

### Help Clients Describe the Future They Want in Outcome Language

The goal of counseling, as emphasized again and again, is neither discussing nor planning nor engaging in activities. Helping is about problem-managing outcomes. "I want to start doing some exercise" is an activity rather than an outcome. "Within 6 months I will be running three miles in less than 30 minutes at least four times a week" is an outcome. It is a pattern of behavior that will be in place by a certain time. If a client says, "My goal is to get some training in interpersonal communication skills," then she is stating her goal as a set of activities rather than as an accomplishment. But if she says that she wants to become a better listener as a wife and mother, then she is stating her goal as an accomplishment, even though "better listener" needs further clarification. Goals stated as outcomes provide direction for clients.

Let us return to Karl, the ex-soldier who has been suffering from a variety of ailments associated with PTSD, and Laura, his therapist. As we have seen, Laura, Karl's counselor, has a good relationship with him. She has helped Karl tell his story and has helped him challenge some of his self-defeating thinking, especially his tendency to blame himself for the deaths of his comrades. She quickly went on to help Karl focus on what he wanted from life. They moved back and forth between Stages I and II, between problems and possibilities for a better future. Eventually, Karl began talking about his real needs and wants—that is, what he needed to "get back to his old self." Here is an excerpt from their dialogue. Their dialogue involves Peter, an ex-soldier who has successfully managed his bout with PTSD and is now Karl's "buddy."

**KARL:** I've said that I want a more "normal" social life, but now I've got some second thoughts. You know I get on well with Peter. And you also know that I'm still not totally comfortable with you. I'm comfortable with Peter because he's a soldier. But you represent a different kind of social life. The civilian one. I think we're getting along better, but we're not there yet.

**LAURA:** So even when you say you want a better social life as a civilian, you hesitate to do anything about it because, in a way, it's a different world. Could you describe what you would like that world to look like? Not a total picture and no definite time frame, but some of bits and pieces. Some of the details.

**KARL:** Well, I'd like to be seeing women again. I'm not talking about marriage. But some special woman friend who sees me as an ordinary guy.

It is helpful when clients draw “pictures,” as it were, of what they want. The terms “special woman friend” and “ordinary guy” are evocative because they are concrete.

At one point, Karl says that he wants to become “more disciplined.” He has a part-time job and only the minimal of social life. He’s also taking a business course at a local junior college. The course deals with an overview of business basics. He spends a lot of time on his own and the discipline that he associates with the army has escaped him. In the army he left productive even when the “productivity” did not have a lot of meaning. Almost discipline for the sake of discipline. Laura helps him get more specific.

**LAURA:** Discipline is a kind of wide area. What do you want to focus on?

**KARL:** Well, if I’m going to get more out of life, I’m going to have to put more into it. I need to look at the time I spend sleeping. I’ve been going to bed whenever I feel like it and getting up whenever I feel like it. It was the only way I could get rid of those thoughts and the anxiety. But I’m not nearly as anxious as I used to be. Things are calming down.

**LAURA:** So more disciplined means a more regular sleep schedule because there’s no particular reason now for not having one.

**KARL:** Yeah, sleeping whenever I want is just a bad habit. It’s part of my aimlessness. And I can’t get things done if I’m asleep.

Karl goes on to translate “more disciplined” into more specific problem-managing needs and wants related to school, work, and even his appearance. Greater discipline, once translated into specific patterns of behavior, could have a decidedly positive impact on his life.

## Help Clients Move from Broad Aims to Clear and Specific Goals

Counselors often add value by helping clients move from good intentions and vague desires to broad aims and then on to quite specific goals.

**Good intentions** “I need to do something about this” is a statement of intent. However, even though good intentions are a good start, they need to be translated into aims and goals. In the following example, the client, Jon, has been discussing his relationship with his wife and children. The counselor has been helping him see that his “commitment to work” is perceived negatively by his family. Jon is open to challenge and is a fast learner.

**JON:** Boy, this session has been an eye-opener for me. I’ve really been blind. My wife and kids do not see my investment—rather, my overinvestment—in work as something I’m doing *for* them. I’ve been fooling myself, telling myself that I’m working hard to get them the good things in life. In fact, I’m spending most of my time at work because I like it. My work is mainly for me. It’s time for me to realign some of my priorities.

The last statement is a good intention, an indication on Jon’s part that he wants to do something about a problem now that he sees it more clearly. It may be

that Jon will now go out and put a different pattern of behavior in place without further help from the counselor. Or he may benefit from some help in realigning his priorities.

**Broad aims** A broad aim is more than a good intention. It has content—that is, it identifies the area in which the client wants to work and makes some general statement about that area. Let us return to the example of Jon and his overinvestment in work.

**JON:** I do not think I'm spending so much time at work in order to run away from family life. But family life is deteriorating because I'm just not around enough. I must spend more time with my wife and kids. Actually, it's not just a case of must. I want to.

Jon moves from a declaration of intent to an aim or a broad goal, spending more time at home. But he still has not created a picture of what that would look like.

**Specific goals** To help Jon move toward greater specificity, the counselor uses such probes as "Tell me what 'spending more time at home' will look like."

**JON:** I'm going to consistently spend three out of four weekends a month at home. During the week I will make every effort to work no more than two evenings.

**COUNSELOR:** So you'll be at home a lot more. Tell me what you'll be doing with all this time.

Notice how much more specific Jon's statement is than "I'm going to spend more time with my family." He sets a goal as a specific pattern of behavior he wants to put in place. But his goal as stated deals with quantity, not quality. The counselor's probe is really an invitation to self-challenge. It is not just the amount of time Jon is going to spend with his family but also the kinds of things he will be doing. Quality time, if you want.

**Instrumental versus ultimate goals** This example brings up the difference between instrumental goals and higher-order or ultimate goals. Jon's ultimate goal is "a good family life." Such a goal, once spelled out, will differ from family to family and from culture to culture. Think of your own definition of good family life. Therefore when Jon says that one of his goals is spending more time at home, he is talking about an instrumental goal. Unless he is there, he cannot do things with his wife and kids. But although just "being there" is a goal because it is a pattern of behavior in place, it is certainly not Jon's ultimate goal. But Jon is not worried about the ultimate goal. When he is there, they have a rich family life together. That is not the problem. However, because instrumental goals are strategies for achieving higher-order goals, it is important to make sure that the client has clarity about the higher-order goal. If Jon was spending a lot of time at the office because he did not like being with his wife and kids or because there was a great deal of conflict at home, then his higher-order goal would be something like "experiencing the stimulation of an exciting workplace," if home

life was dull, or “peace of mind, if home life was full of conflict. When you are helping clients design and shape instrumental goals, make sure they can answer the “instrumental-for-what?” question.

**Goal setting and evaluating progress** If the goal is clear and specific enough, the client will be able to determine progress toward the goal. If there is a two-way feedback system in place, client and helper can collaborate routinely on goal clarification. Being able to measure progress is an important incentive. If goals are stated too broadly, it is difficult to determine both progress and accomplishment. “I want to have a better relationship with my wife” is a very broad goal, difficult to verify. “I want to socialize more, you know, with couples we both enjoy” comes closer, but “socialize more” needs more clarity. It is not always necessary to count things to determine whether a progress is being made toward a goal has been reached, though sometimes counting is helpful. Helping is about living more fully, not about accounting activities. At a minimum, however, desired outcomes need to be capable of being verified in some way. For instance, a couple might say something like “Our relationship is better, not because we’ve stop squabbling. In fact, we’ve discovered that we like to squabble. But life is better because the meanness has gone out of our squabbling. We accept each other more. We listen more carefully, we talk about more personal concerns, we are more relaxed, and we make more mutual decisions about issues that affect us both.” This couple does not need a scientific experiment to verify that they have improved their relationship.

### Help Clients Establish Goals That Make a Difference

Clients need goals with substance. What do we mean by substance? In counseling goals have substance to the degree that they make some significant contribution toward managing the original problem situation or developing some opportunity. Goals are not substantive unless they are on target. Consider this case.

Vittorio ran the family business. His son, Anthony, worked in sales. After spending a few years learning the business and getting an MBA part time at a local university, Anthony wanted more responsibility and authority. His father never thought that he was “ready.” They began arguing quite a bit, and their relationship suffered from it. Finally, a friend of the family persuaded them to spend time with a consultant-counselor who worked with small family businesses. He spent relatively little time listening to their problems. After all, he had seen this same problem over and over again—the reluctance and conservatism of the father, the pushiness of the son.

Vittorio wanted the business to stay on a tried-and-true course. Anthony wanted to be the company’s marketer, to move it into new territory. After a number of discussions with the consultant-counselor, they settled on this scenario: A “marketing department” headed by Anthony would be created. He could divide his time between sales and marketing as he saw fit, provided that he maintained the current level of sales. Vittorio agreed not to interfere. They would meet once a month with the consultant-counselor to discuss problems and progress. Vittorio insisted that the consultant’s fee come from increased sales. After some initial turmoil, the bickering decreased dramatically. Anthony easily found new customers, although they demanded modifications in the product line, which Vittorio reluctantly approved. Both sales and margins increased to the point that they needed another person in sales.



Not all issues in family businesses are handled as easily. In fact, a few years later, Anthony left the business and founded his own business. But the goal package they worked out—the deal they cut—made quite a difference both in the father-son relationship and in the business.

Goals have substance to the degree that they help clients “stretch” themselves. As Locke and Latham (1984, pp. 21, 26) noted, “Extensive research . . . has established that, within reasonable limits, the . . . more challenging the goal, the better the resulting performance. . . . People try harder to attain the hard goal. They exert more effort. . . . In short, people become motivated in proportion to the level of challenge with which they are faced. . . .” Even goals that cannot be fully reached will lead to high effort levels, provided that partial success can be achieved and is rewarded. Consider the following case.

A young woman became a quadriplegic because of an auto accident. In the beginning, she was full of self-loathing—“The accident was all my fault; I was just stupid.” She was close to despair. Over time, however, with the help of a counselor, she came to see herself, not as a victim of her own “stupidity,” but as someone who could bring hope to young people with life-changing afflictions. In her spare time, she visited young patients in hospitals and rehabilitation centers, got some to join self-help groups, and generally helped people like herself to manage an impossible situation in a more humane way. One day she said to her counselor, “The best thing I ever did was to stop being a victim and become a fellow traveler with people like myself. The last 2 years, though bitter at times, have been the best years of my life.” She had set her goals quite high—becoming an outgoing helper instead of remaining a self-centered victim, but they proved to be quite realistic.

Of course, when it comes to goals, “challenging” should not mean “impossible.” There seems to be a curvilinear relationship between goal difficulty and goal performance. If the goal is too easy, people see it as trivial and ignore it. If the goal is too difficult, it is not accepted. However, this difficulty-performance ratio differs from person to person. What is small for some is big for others.

### Help Clients Formulate Realistic Goals

Setting stretch goals can help clients energize themselves. They rise to the challenge. On the other hand, goals set too high can do more harm than good. Locke and Latham (1984, p. 39) put it succinctly:

Nothing breeds success like success. Conversely, nothing causes feelings of despair like perpetual failure. A primary purpose of goal setting is to increase the motivation level of the individual. But goal setting can have precisely the opposite effect if it produces a yardstick that constantly makes the individual feel inadequate.

A goal is realistic if the client has access to the resources needed to accomplish it, the goal is under the client’s control, and external circumstances do not prevent its accomplishment. While some clients are pessimistic about setting goals, others are overly optimistic. There is a rich literature on unrealistic optimism in general (Shepperd, Klein, Waters, & Weinstein, 2013; Shepperd, Waters, Weinstein, & Klein, 2015). The consequences, though often overlooked, can be self-defeating (Shepperd, Pogge, & Howell, 2017). Most entrepreneurial ventures fail, though failure does not stop them from moving on to the next venture. However, most

of your clients will not be entrepreneurs (though, as we have seen in Chapter 3, you can encourage them to tap into whatever entrepreneurial resources they have to manage problem situations).

Two years ago the last of Myra and Ed's four children left the nest. They both worked, he as a manager of a large retailer's local store, she as a computer consultant. The economy proved to be unkind to both of them. He lost his job because the retailer closed 500 of its stores. The online giants were doing in many retailers. Her business dwindled both because the smartphone was taking the place of computers and those who had grown up with computers could tend to them themselves. The empty house was also taking its toll. When both were busy with work and family, their relationship seemed fine. Now they were squabbling over little things and generally getting into each other's hair. They were seeing a counselor off and on.

One evening they were out with friends at a very nice Italian restaurant. On the way home they mentioned how nice things were. Then, almost at the same time, they said, "Let's start our own Italian restaurant." They believed that they had the skills to do so. She was a very good cook. And they had the resources to do so. Both found planning a new business invigorating. It worked magic for their relationship. They were doing something of substance together. Even the counselor said, "Go for it!"

To make a long story short, in the end everything fell apart, even their relationship. They created an Italian restaurant in a neighborhood that already had two Italian restaurants. "They serve junk," they said, but unfortunately their customers seemed to like the junk. They went over budget. They knew nothing about marketing. The list goes on.

Helping clients walk the line between too much caution and too much optimism in setting goals and crafting a future is one of your challenges. And never say, "Go for it."

***Help clients choose goals for which the resources are available*** It does little good to help clients develop specific, substantive, and verifiable goals if the resources needed for their accomplishment are not available. Consider the case of Rory, who has had to take a demotion because of merger and extensive restructuring.

Rory now wants to leave the company and become a consultant. He does not have the assertiveness, marketing savvy, industry expertise, or interpersonal style needed to become an effective consultant. Even if he did, he does not have the financial resources needed to tide him over while he develops a business. Challenged by the outplacement counselor, Rory changes his focus. Graphic design is an avocation of his. He is not good enough to take a technical position in the company's design department, but he does apply for a supervisory role in that department. He is good with people, very good at scheduling and planning, and knows enough about graphic design to discuss issues meaningfully with the members of the department.

Rory combines his managerial skills with his interest in graphic design to move in a more realistic direction. The move is challenging, but it can have a substantial impact on his work life. For instance, the opportunity to hone his graphic design skills will open up further career possibilities.

***Help clients choose goals that are under their control*** Sometimes clients defeat their own purposes by setting goals that are not under their control. For instance, it is common for people to believe that their problems would be solved if only other people would not act the way they do. In most cases, however, we do not have any direct control over the ways others act. Consider the following example.

Tony, a 16-year-old boy, felt that he was the victim of his parents' inability to relate to each other. Each tried to use him in the struggle, and at times he felt like a Ping-Pong ball. A counselor helped him see that he could probably do little to control his parents' behavior but that he might be able to do quite a bit to control his reactions to his parents' attempts to use him. For instance, when his parents started to fight, he could simply leave instead of trying to "help." If either tried to enlist him as an ally, he could say that he had no way of knowing who was right. Tony also worked at creating a good social life outside the home. That helped him weather the tensions he experienced when at home.

Tony needed a new way of managing his interactions with his parents to minimize their attempts to use him as a pawn in their own interpersonal game. Goals are not under clients' control if external forces that they cannot influence block them.

### **Help Clients Set Prudent Goals**

Realistic and prudent are not the same things. A goal may be realistic, that is, it can be accomplished, but it may not be prudent. Although the helping model described in this book encourages a bias toward client action, action needs to be both directional and wise. Discussing and setting goals should contribute to both direction and wisdom. The following case begins poorly but ends well.

Harry was a sophomore in college who was admitted to a state mental hospital because of some bizarre behavior at the university. He was one of the disc jockeys for the university radio station. College officials noticed him one day when he put on an attention-getting performance that included rather lengthy dramatizations of grandiose religious themes. In the hospital, the counselors soon discovered that this quite pleasant, likable young man was actually a loner. Everyone who knew him at the university thought that he had many friends, but in fact he did not. The campus was large, and his lack of friends went unnoticed. Harry was soon released from the hospital but returned weekly for therapy. At one point he talked about his relationships with women. Once it became clear to him that his meetings with women were perfunctory and almost always took place in groups—he had imagined that he had a rather full social life with women—Harry launched a full program of getting involved with the opposite sex. His efforts ended in disaster, however, because Harry had some basic sexual and communication problems. He also had serious doubts about his own worth and therefore found it difficult to make a gift of himself to others. He ended up in the hospital again.

The counselor helped Harry get over his sense of failure by emphasizing what Harry could learn from the "disaster." With the therapist's help, Harry returned to the problem-clarification and new-perspectives part of the helping process and then established more realistic short-term goals regarding getting back "into community." The direction was the same—establishing a realistic social life—but the goals were now more prudent because they were "bite-size."

There are two kinds of prudence—playing it safe is one; doing the wise but challenging thing is the other. Problem management and opportunity development should be challenging.

### **Help Clients Set Sustainable Goals**

Clients need to commit themselves to goals that have staying power. One separated couple said that they wanted to get back together again. They did so only to get divorced again within six months. Their goal of getting back together again was achievable but not sustainable. Perhaps they should have asked themselves, “What do we need to do not only to get back together but also to stay together? What would our marriage have to look like to become and remain workable?” In discretionary-change situations, the issue of sustainability needs to be visited early on.

Many Alcoholics Anonymous–like programs work because of their one-day-at-a-time approach. The goal of being, say, drug-free has to be sustained only over a single day. The next day is a new era. In a previous example, Vittorio and Anthony’s arrangement had enough staying power to produce good results in the short term. It also allowed them to reset their relationship and to improve the business. The goal was not designed to produce a lasting business arrangement because, in the end, Anthony’s aspirations were bigger than the family business.

### **Help Clients Choose Flexible Goals**

In many cases, goals have to be adapted to changing realities. Therefore there might be some trade-offs between goal specificity and goal flexibility in uncertain situations. Sometimes making goals too specific or too rigid does not allow clients to take advantage of emerging opportunities.

Even though he liked the work and even the company he worked for, Jessie felt like a second-class citizen. He thought that his supervisor gave him most of the dirty work and that there was an undercurrent of prejudice against Hispanics in his department. Jessie wanted to quit and get another job, one that would pay the same relatively good wages he was now earning. A counselor helped Jessie challenge his choice. Even though the economy was booming, the industry in which Jessie was working was in recession. There were few jobs available for workers with Jessie’s set of skills.

The counselor helped Jessie choose an interim goal that was more flexible and more directly related to coping with his present situation. The interim goal was to use his time preparing himself for a better job outside this industry. In 6 months to a year he could be better prepared for a career in a still healthy economy. Jessie began volunteering for special assignments that helped him learn some new skills and took some crash courses dealing with computers and the Internet. He felt good about what he was learning and more easily ignored the prejudice.

Counseling is a living, organic process. Just as organisms adapt to their changing environments, clients’ choices need to be adapted to their changing circumstances.

### **Help Clients Choose Goals Consistent with Their Values**

Although helping is a process of social influence, it remains ethical only if it respects, within reason, the values of the client. Values are criteria we use to

make decisions. Helpers may invite clients to reexamine their values, but they should not encourage clients to perform actions that are not in keeping with their values.

The son of Vincente and Consuela is in a coma in the hospital after an automobile accident. He needs a life-support system to remain alive. His parents are experiencing a great deal of uncertainty, pain, and anxiety. They have been told that there is practically no chance that their son will ever come out of the coma. One possibility is to terminate the life-support system. The counselor should not urge them to terminate the life-support system if that is counter to their values. She can help them explore and clarify their values. In this case, the counselor suggests that they discuss their decision with their clergyman. In doing so, they find out that the termination of the life-support system would not be against the tenets of their religion. Now they are free to explore other values that relate to their decision.

Some problems involve a client's trying to pursue contradictory goals or values. Karl, the ex-Marine, came to realize that he wanted to get a degree in business, but he also wanted to make a decent living as soon as possible. The former goal would put him in debt, but failing to get a college education would lessen his chances of securing the kind of job he wanted. The counselor helps him identify and use his values to consider some trade-offs. Karl chooses to work part time and go to school part time. He chooses an office job instead of one in construction. Even though the latter pays better, it would be much more exhausting and would leave him with little energy for school.

### Help Clients Establish Realistic Time Frames for Accomplishing Goals

Goals that are to be accomplished "sometime or other" probably won't be accomplished at all. Therefore helping clients put some time frames in their goals can add value. Greenberg (1986) talked about immediate, intermediate, and final outcomes. Here's what they look like when applied to Janette's problem situation. She has begun to hate her passive lifestyle. She easily lets others take advantage of her. She needs to become more assertive and to stand up for her own rights.

- *Immediate outcomes* are changes in attitudes and behaviors evident in the helping sessions themselves. For Janette, the helping sessions constitute a safe forum for her to become more assertive. In her dialogues with her counselor, she learns and practices the skills of being more assertive.
- *Intermediate outcomes* are changes in attitudes and behaviors that lead to further change. It takes Janette a while to transfer her assertiveness skills both to the workplace and to her social life. She chooses relatively safe situations to practice being more assertive. For instance, she stands up to her mother more.
- *Final outcomes* refer to the completion of the overall program for constructive change through which problems are managed and opportunities developed. It takes more than two years for Janette to become assertive in a consistent, day-to-day way.

There is no such thing as a set time frame for every client. Some goals need to be accomplished now, some soon; others are short-term goals; still others are

long term. Consider the case of a priest who had been unjustly accused of child molestation.

- A “*now*” goal: some immediate relief from debilitating anxiety attacks and keeping his equilibrium during the investigation and court procedures
- A “*soon*” goal: obtaining the right kind of legal aid
- A *short-term* goal: winning the court case
- A *long-term* goal: reestablishing his credibility in the community and learning how to live with those who would continue to suspect him

There is no particular formula for helping all clients choose the right mix of goals at the right time and in the right sequence. Although helping is based on problem-management principles, it remains an art. Box 10.1 outlines questions on goal setting that you can help clients answer.

Once more, it is not always necessary to make sure that each goal in a client’s program for constructive change has all the characteristics outlined in this chapter. For some clients, identifying broad goals is enough to kick-start the entire problem-management and opportunity-development process. They shape the goals themselves. For others, some help in formulating more specific goals is called for. The principle is clear: Help clients develop goals that have some sort of agency—if not urgency—built in. In one case, this may mean helping a client deal with clarity; in another, with substance; in still another, with realism, values, or time frame.

### Remember that Goals Can Emerge

Finally, it is not always a question of designing and setting goals in an explicit way. Rather, goals can naturally emerge through the client-helper dialogue or the client’s interaction with his or her environment in everyday life. Entrepreneurs, design-thinking, and action learning approaches to change tend to favor emerging goals. They emerge from the various ways clients are helped to do

#### BOX 10.1

#### Questions for Choosing and Shaping Goals

Help clients ask themselves these kinds of questions to shape their goals.

- Is my goal stated in outcome or results language?
- Is my goal specific enough to drive behavior?
- How will I know when I have accomplished it?
- If I accomplish this goal, will it make a difference?
- Will it really help manage the problems and opportunities I have identified?
- Does this goal have “bite” while remaining prudent?
- Is it realistic? Is it doable? Can I sustain this goal over the long haul?
- Does this goal have some flexibility?
- Is this goal in keeping with my values?
- Have I set a realistic time frame for the accomplishment of the goal?

things throughout the helping process. Often when clients talk about problems and unused opportunities, possible goals and action strategies bubble up. Once clients are helped to clarify a problem situation through a combination of probing, empathic highlights, and challenge, they begin to see more clearly what they want and what they have to do to manage the problem. Indeed, some clients must first act in some way before they find out just what they want to do. After goals begin to emerge, counselors can help clients clarify them and find ways to implement them. However, “emerge” should not mean that clients wait around until “something comes up.” Nor should it mean that clients try many different solutions in the hope that one of them will work. These kinds of “emergence” tend to be self-defeating.

Although goals do often emerge, explicit goal setting is not to be underrated. Taussig (1987) showed that clients respond positively to goal setting even when goals are set very early in the counseling process. A client-centered, “no one right formula” approach seems to be best. Although all clients need focus and direction in managing problems and developing opportunities, what focus and direction will look like will differ from client to client.

## II-C: Help Clients Commit Themselves to Their Goals **LO 10.5**

After reviewing a number of books on human evolution and where the human race seems to be headed, Tickell (2005, p. W5) says with some sorrow, “If there is optimism about human ability to cope, there is pessimism about the human will to do so.” Thus the necessity of addressing commitment. As mentioned earlier, Task II-C is not really a sequential step but rather a dimension that should permeate the entire helping process. Here it is question of commitment to a better future. Clients may formulate goals, but that does not mean that they are willing to do whatever is necessary to achieve them. Once clients state what they want and set goals, the battle is joined, as it were. And, as a Prussian General once remarked, “no battle plan survives contact with the enemy.” The enemy, in this case, consists in all the obstacles to staying committed to the goal. It is as if the client’s “old self” or old lifestyle begins vying for resources with the client’s potential “new self” or new lifestyle. On a more positive note, history is full of examples of people whose strength of will to accomplish some goal has enabled them to do seemingly impossible things.

A woman with two sons in their 20s was dying of cancer. The doctors thought she could go at any time. However, one day she told the doctor that she wanted to live to see her older son get married six months hence. The doctor talked vaguely about “trusting in God” and “playing the cards she had been dealt.” Against all odds, the woman lived to see her son get married. Her doctor was at the wedding. During the reception, he said to her and, “Well, you got what you wanted. Despite the way things are going, you must be deeply satisfied.” She looked at him wryly and said, “But, Doctor, my second son will get married someday.”

Although the job of counselors is not to encourage clients to heroic efforts, counselors should not undersell clients, either. Box 10.2 indicates the kinds of



**BOX 10.2****Questions for Evaluating Clients' Commitment to Goals**

Here are the kinds of questions you can help clients ask themselves in order to test their commitment to goals they are setting.

- What is my state of readiness for change in this area at this time?
- How badly do I want what I say I want?
- How hard am I willing to work?
- To what degree am I choosing this goal freely?
- How highly do I rate the personal appeal of this goal?
- How do I know I have the courage to work on this?
- What's pushing me to choose this goal?
- What incentives do I have for pursuing this change agenda?
- What rewards can I expect if I work on this agenda?
- If this goal is in any way being imposed by others, what am I doing to make it my own?
- What difficulties am I experiencing in committing myself to this goal?
- In what way is it possible that my commitment is not a true commitment?
- What can I do to get rid of the disincentives and overcome the obstacles?
- What can I do to increase my level of commitment?
- In what ways can the goal be reformulated to make it more appealing?
- To what degree is the timing for pursuing this goal poor?
- What do I have to do to stay committed?
- What resources can help me? What kind of support do I need?

questions you can help clients ask themselves about their commitment to their change agendas.

There is a range of things you can do to help clients in their initial commitment to goals and the kind of action that is a sign of that commitment. Read the "bias toward action" section of Chapter 3 and review all of Chapter 8 for ways of helping clients commit themselves. Counselors can help clients by helping them make goals appealing, by helping them enhance their sense of ownership, and by helping them deal with competing agendas.

### **Review the Relationship of Self-Efficacy to Commitment: A Case**

People's sense of self-efficacy can be strengthened in a variety of ways. Lest self-efficacy be seen as a paradigm that applies only to the weak, let us take the case of a very strong manager, let us call him Nick, who wanted to change his abrasive supervisory style but was doubtful that he could do so. "After all these years, I am what I am," he would say. It would have been silly to merely tell him, "Nick, you can do it; just believe in yourself." It was necessary to help him do a number of things to help strengthen his sense of self-efficacy in supervision.

***Skills: Make sure that clients have the skills they need to perform desired tasks***

Self-efficacy is based on ability and the conviction that you can use this ability to get a task done. Nick first read about and then attended some skill-building sessions on such “soft” skills as listening, responding with empathic highlights, giving feedback that is softer on the person but harder on the problem, and constructive challenging. In truth, he had many of these skills, but they lay dormant. These short training experiences put him back in touch with some things he could do but didn’t do. Please note, however, that merely acquiring skills does not by itself increase clients’ self-efficacy. The way they acquire them must give them a sense of competence. “I now have these skills and I am positive that I can use them to get this task done.”

***Corrective feedback: Provide feedback that is based on deficiencies in performance, not on deficiencies in the client’s personality***

Corrective feedback can help clients develop a sense of self-efficacy because it helps clear away barriers to the use of resources. Because I attended many meetings with Nick, I routinely described the ups and downs of his performance. I’d say such things as, “Nick, in yesterday’s meeting you listened to and responded to everyone’s ideas. Let me make a proposal. You do not have to respond, as you did, in a positive way to every suggestion. Crap is still crap. Do some sorting as you listen and respond. Show why good ideas are good and why lousy ideas are bad. Then, whether the ideas are good or bad, everyone learns something.”

When corrective feedback sounds like an attack on clients’ personalities, their sense of self-efficacy will suffer. My feedback helped Nick’s self-efficacy belief because it pointed out that he could be decent and listen well and still use his excellent critical abilities. People would leave the room enlightened, not angry. When you give feedback, you would do well to ask yourself, “In what ways will this feedback help increase the client’s sense of self-efficacy?”

***Positive feedback: Provide positive feedback and make it as specific as corrective feedback***

Positive feedback strengthens clients’ self-efficacy by emphasizing their strengths and reinforcing what they do well. This is especially true when it is specific. Too often negative feedback is very detailed, whereas positive feedback is perfunctory—“Nice job.” This and other throwaway phrases probably sound like clichés. Here’s one bit of feedback I gave Nick: “Yesterday, you interrupted Jeff, who was engaging in another one of his monologues. You summarized his main ideas. Then, with a few questions you showed him why only part of his plan was viable. The others were glad you took Jeff on. He learned something. And you saved us all a lot of time.”

The formula for giving specific positive feedback goes something like this. “Here’s what you did. Here’s the positive outcome it had. And here’s the wider upbeat impact.” Helping Nick see the value of this pattern of behavior helped him engage in it more frequently and increased his sense of self-efficacy. “I can combine the hard stuff and the soft stuff.” Clients need to see feedback as information they need to accomplish a task.

***Success as a reinforcer: Invite clients to challenge themselves to engage in actions that produce positive results***

Even small successes can increase a client's sense of self-efficacy. Success is reinforcing. Often success in a small endeavor will give clients the courage to try something more difficult. "I can do even more." Nick began delegating a few minor tasks to some of his direct reports. They handled their assignments very well. When I commented, "They seem to be doing pretty well," Nick replied, "I think that I can safely begin to put more on their plate. They like it, and I like seeing them succeed." Successful delegation increased Nick's sense of supervisory self-efficacy. He could say to himself more assuredly, "I can delegate without worrying whether or not it's going to get done." Make sure, however, that the link between success and increased self-confidence is forged. A series of successes on its own does not necessarily increase the strength of a client's self-efficacy beliefs. Success has to be linked to a sense of increased competence.

***Models: Help clients increase their own sense of self-efficacy by learning from others***

I asked Nick to name the best manager in the division. He mentioned a name. "What's he like?" I asked. Of course Nick talked about how competent this guy was, how effective he was in getting results, and how tough he was. Tongue in cheek, I remarked, "But I suppose that he's not very good with people." Nick exploded. "Of course he's fair. He's as good at all of this soft stuff as anyone else." He went on to name ways in which the guy was "good with people." Then suddenly he stopped, looked at me, and smiled. "Caught me, didn't you?" Learning makes clients more competent and increases their self-efficacy. Learning from models is, as we have seen, a bit tricky. Nick had too much pride to think that he could learn very much from others.

***Providing encouragement: Support clients' self-efficacy beliefs without being patronizing***

We took a brief look at motivational interviewing and encouragement in Chapter 8. However, if your support is to increase clients' sense of self-efficacy, it must be real, and what you support in them must be real. Encouragement and support must be tailored to each client in each instance. A supportive remark to one client might sound patronizing to another. Had I patronized Nick—"Give it a try, Nick, I know that you can do it"—I would have failed. My encouragement was, let us say, more subtle and indirect.

***Reducing fear and anxiety: Help clients overcome their fears***

Fear blocks clients' sense of self-efficacy. If clients fear that they will fail, they will be reluctant to act. Therefore procedures that reduce fear and anxiety help heighten their sense of self-efficacy. Deep down, Nick was fearful of two things regarding changing his supervisory style—messing up the business and making a fool of himself. As he tentatively changed some of his supervisory practices, business results held steady. He even noticed that two of his team members seemed to become more productive. Helping him allay his fear of making a fool of himself by being too soft was a bit trickier. His behavior outside the office came to the rescue. Although he was often an ogre in the office, Nick was very upbeat when we visited teams out in the field. He was as good at "rallying the troops" as anyone I have ever seen. And he was real. Discussions about his two different styles

helped him get rid of fears that he would make a fool of himself with his direct reports by engaging them instead of driving them.

Admittedly, I was Nick's coach and consultant, not his therapist. In the business world "challenge" isn't always a bad word. Still, for the most part, I was invitational rather than challenging. I suggested ways of acting. That said, you would probably have to adapt the entire scenario with Nick to the needs and capabilities of your clients. Once more, the principles outlined above are things that you can do, not things that you must do with your clients. You have to develop your own style as a therapist and no one style is the "right" style. A good friend of mine is one of the best counselors I know. Her clients quickly learn that she is totally "for" them. But she does not tolerate nonsense. If a client is rambling on about things that are not contributing to progress, she does not hesitate to say, "Tim, I think we've spent too much time on this issue. Let us move on." That's her style, not necessarily yours or mine. But she is very successful.

## See the Three Tasks of Stage II as Triggers for Action **LO 10.6**

The three tasks of Stage II, setting goals, are dynamic in that they promote lie-enhancing action. Let us take a look at a few examples.

**Task A: Developing possibilities for a better future** Developing possibilities is just what some clients need in order to move into action. It frees them from thinking solely about problem situations and unused resources and enables them to begin fashioning a better future. Once they identify some of their wants and needs and consider a few possible goals, they move into action.

Francine is depressed because her aging and debilitated father has been picking on her even though she has put off marriage in order to take care of him. Some of the things he says to her are quite hurtful. The situation has begun to affect her productivity at work. A counselor suggests to her that the hurtful things her father says to her is not her father but his illness speaking. This gives her a whole new perspective and frees her to think about other possibilities. Once she spends a bit of time brainstorming answers to the counselor's question—"What do you want for both yourself and your father?"—She says things like, "I'd like both of us to go through this with our dignity intact" and "I'd like to be living the kind of life he would want me to have if his mind wasn't so clouded." Once she brainstorms some possibilities for a better arrangement with her father, she needs little further help. Her usual resourcefulness returns. She gets on with life.

**Task B: Choosing and shaping goals** Task B is the trigger for action. Choosing and shaping the right goals can help clients see the future in a very different way. Once they have a clear idea of just what they want or need, they go for it.

While driving under the influence of alcohol, Nero, a man in his early 20s, had a car accident that took his wife's life. Strangely, Nero is filled with self-pity rather than remorse. The counselor, at her wit's end, invites him to take a good look at the way he is wrapped up in himself. She says, "Who's the most decent person you know?" After fudging around a bit, he names Saul, an uncle. "Describe his lifestyle to me," she

urges, “What makes him so decent?” With some prodding, he describes the lifestyle of this decent man. Then she says, “Do the description again, but instead of saying ‘Saul’ say ‘Nero.’” Nero sweats, but the session has enormous impact on him. The picture of the contrast between his uncle’s lifestyle and his own haunts him for days after. But he begins to stop feeling so sorry for himself; he visits his wife’s parents and begs their forgiveness. He begins to see that there are other people in the world besides Nero.

**Task C: The search for incentives for commitment** Incentives trigger action. Once they see what’s in it “for me”—a kind of upbeat and productive selfishness, if you will—they move into action.

Callahan is seeing a consultant because he is very distressed. He owns and runs a small business. A few of his employees have gotten together and filed a workplace discrimination suit against him. The “troublemakers” he calls them, meaning a few women, a couple of Hispanics, and three African Americans. The consultant finds out that Callahan believes that they are “decent workers.” In fact, they are more than decent. Callahan tells the counselor that he is paying them “scale,” but actually he underpays them. Callahan also says that he doesn’t expect his supervisors to “bend over backwards to become their friends.” The truth is that some supervisors—all but two are white males—are sometimes abusive.

The consultant invites Callahan to consider attending an excellent program on diversity “before some court orders you to.” A couple of weeks after returning from the program, he has a session with the consultant. He says that he has never even once considered the advantages of diversity in the workplace. All the term had meant to him was “a bunch of politicians looking for votes.” Now that he sees the business reasons for diversity, he knows there are a few things he could do, but he still needs the consultant’s help and guidance. “I do not want to look like a soft jerk.” Callahan’s newly acquired “human touch” is far from being soft. He remains a rather rough-and-ready business guy.

Callahan did not change his stripes overnight, but finding a package of incentives certainly helped him move toward much needed action. Who knows, the whole situation might have even made a dent in his deeply ingrained prejudices.

## Explore the Shadow Side of Goal Setting LO 10.7

Despite the advantages of goal setting outlined in this chapter, some helpers and clients seem to conspire to avoid goal setting as an explicit process. It is puzzling to see counselors helping clients explore problem situations and unused opportunities and then stopping short of asking them what they want and helping them set goals. As Bandura (1990, p. xii) put it, “Despite this unprecedented level of empirical support [for the advantages of goal setting], goal theory has not been accorded the prominence it deserves in mainstream psychology.” Years ago, the same concern was expressed differently. A U.S. developmental psychologist was talking to a Russian developmental psychologist. The Russian said, “It seems to me that American researchers are constantly seeking to explain how a child came to be what he is. We in the USSR are striving to discover how he can become what he not yet is” (see Bronfenbrenner, 1977, p. 258). One of the main reasons

that counselors do not help clients develop realistic life-enhancing goals is that they are not trained to do so.

There are other reasons. *First*, some clients see goal setting as very rational, perhaps too rational. Their lives are so messy and goal setting seems sterile. Both helpers and clients object to this overly rational approach. There is a dilemma. On the one hand, many clients need or would benefit by a rigorous application of the problem-management process, including goal setting. On the other, they resist its rationality and discipline. They find it alien.

*Second*, goal setting means that clients have to move out of the relatively safe harbor of discussing problem situations and of exploring the possible roots of those problems in the past and move into the uncharted waters of the future. This may be uncomfortable for client and helper alike.

*Third*, clients who set goals and commit themselves to them move beyond the victim-of-my-problems game. Victimhood and self-responsibility make poor bedfellows.

*Fourth*, goal setting involves clients' placing demands on themselves, making decisions, committing themselves, and moving to action. If I say, "This is what I want," then, at least logically, I must also say, "Here is what I am going to do to get it. I know the price and I'm willing to pay it." Because this demands work and pain, clients will not always be grateful for this kind of "help."

*Fifth*, though goals are liberating in many respects, they also hem clients in. If a woman chooses a career, then it might not be possible for her to have the kind of marriage she would like. If a man commits himself to one woman, then he can no longer play the field.

There is some truth in the ironic statement "There is only one thing worse than not getting what you want, and that's getting what you want." The responsibilities accompanying getting what you want—a drug-free life, a renewed marriage, custody of the children, a promotion, the peace and quiet of retirement, freedom from an abusing husband—often open up a new set of problems. Even good solutions create new problems. It is one thing for parents to decide to give their children more freedom; it is another to watch them use that freedom. Finally, there is a phenomenon called post-decisional depression. Once choices are made, clients begin to have second thoughts that often keep them from acting on their decisions.

As for action, some clients move into action too quickly. The focus on the future liberates them from the past, and the first few possibilities are very attractive. They fail to get the kind of focus and direction provided by Task B. So they go off half-cocked. Failing to weigh alternatives and shape goals often means that they have to do the process all over again.

Culture plays an important role in goal setting. Wosket (2006) points out that goal setting has cultural implications that helpers too easily overlook.

Objections are sometimes legitimately raised about the endorsement of the pursuit of individual over collective goals that are explicit or implicit in most Eurocentric and westernized approaches to counseling—the Skilled Helper model included. So here the counselor has to be careful not to contaminate the client's process with his or her own conscious or unconscious bias toward the reinforcement of predominant cultural norms attached to goal setting. The process of goal setting can still be

usefully applied to communal or collective contexts, for instance where the client's allegiance to family or cultural expectations prevails over individual preferences or objectives. Committing to a course of action that honors a sense of duty is a legitimate goal. For instance, the goal of keeping the family together may be a high priority for an Irish Catholic woman and one that, if accomplished, might give her more of a sense of achievement and fulfillment than pursuing the individual goal of leaving an unsatisfying relationship.

Effective helpers know what lurks in the shadows of goal setting both for themselves and for their clients and are prepared to manage their own part of it and help clients manage theirs. The answer to all of this lies in helpers' being trained in the entire problem-management process and in their sharing a basic picture of the entire process with the client. Then goal setting, described in the client's language, will be a natural part of the process. Artful helpers weave goal setting, under whatever name, into the flow of helping. They do so by moving easily back and forth among the stages and tasks of the helping process even in brief therapy.

King and Burton (2003) have written a sobering article on "the hazards of goal pursuit." They say that the research, read in one way, suggests that people who pursue goals "ought to endeavor to achieve and approach goals that only slightly implicate the self; that are only moderately important, fairly easy, and moderately abstract; that do not conflict with each other; and that concern the accomplishment of something other than financial gain" (p. 64)—that is, a boring life not worth living. However, there is another way to read the cited research—it is a wonderful compendium of common mistakes made in the pursuit of goals. Read the article and you will discover that just about every negative outcome takes place because of the violation of one or more of the principles outlined in this chapter. It highlights the fact that striving for goals is great, but it's going to cost you. So you better do it right. To be fair, the authors do not suggest avoiding striving for goals just because there are pitfalls along the way. Your job as a therapist is to help client avoid or deal with the pitfalls. They end by saying, "Only a hopelessly adolescent psychology of mental functioning would assert that it is best to care about nothing to avoid disappointment."



# Stage III: Planning- Help Clients Design the Way Forward

## LEARNING OBJECTIVES

### 11.1 Review the Three Tasks of Stage III

### 11.2 Review a Hospital Case That Highlights the Need for Stage-III Skills

### 11.3 III-A: Help Clients Develop Strategies for Accomplishing Their Goals

- Use Brainstorming to Help Clients Discover Strategies
- Use a Variety of Frameworks to Stimulate Clients' Search for Strategies
- Help Clients Find Social Support in Their Efforts to Change
- Help Clients Determine the Skills Needed to Move Forward
- Help Clients Use Possible Strategies as Links to Action

### 11.4 III-B: Help Clients Choose Best-Fit Problem-Managing Strategies

- Learn Something about Choosing Strategies from Bud's Amazing Design-Thinking Odyssey
- Use Criteria for Choosing Goal-Accomplishing Strategies
- Use Strategy Sampling as a Way of Getting the Right Package
- Follow the Balance-Sheet Method for Choosing Strategies
- Be Aware of the Shadow Side of Strategy Selection

### 11.5 III-C: Help Clients Turn Strategies into Viable Plans

- Evaluate the Case of Frank: No Plan of Action
- Understand How Plans Add Value to Clients' Change Programs
- Review Two Approaches to Shaping the Plan
- Claudia's Road to Leadership

### 11.6 Humanize the Mechanics of Problem Management and Opportunity Development

- Build a Planning Mentality into the Helping Process Right from the Start
- Adapt the Helping Process to the Style of the Client
- Devise a Plan for the Client and Then Help the Client Tailor It to His or Her needs
- Help Clients Develop Contingency Plans

### 11.7 Come to Terms with the Explosion of Evidence-Based Treatments

Familiarize Yourself with General Well-Being Programs: Nutrition, Exercise, and Stress Reduction

Start with Clients' Needs in Choosing Evidence-Based Treatments

Learn the Value of Both Evidence-Based Practice and Practice-Based Evidence from the Evidence-Based Treatment Debate

Sometimes Evidence-Based Treatments Do Not Work; Sometimes Non-Evidence-Based Treatments Do Work

## Review the Three Tasks of Stage III LO 11.1

In its broadest sense, planning includes all the tasks of Stages I, II, and III, that is, it deals with exploring problems in living and unused opportunities and moving on to solutions with a Big-S and a small-s. In a narrower sense, planning deals with identifying, choosing, and organizing the strategies needed to accomplish goals. Whereas Stage II is about goals and outcomes, Stage III is about the activities or the work needed to produce those outcomes. It is about “implementation intentions” and implementation itself.

When helped to explore what is going wrong in their lives, clients often ask, “Well, what should I do about it?” That is, they focus on actions they need to take in order to “solve” things. But, as we have seen, action—though totally essential—is valuable only to the degree that it leads to problem-managing and opportunity-developing outcomes. Of course, outcomes are valuable only to the degree that they have a constructive impact on the life of the client. The distinction between action, outcomes, results, and impact is seen in the following example.

Lacy, a 40-year-old single woman, is making a great deal of progress in controlling her drinking through her involvement with an AA program. She attends AA meetings, follows the 12 steps, and stays away from situations that would tempt her to drink, and calls fellow AA members when she feels depressed or when the temptation to drink is pushing her hard. The outcome is that she has stayed sober for over 7 months. She feels that this is quite an accomplishment. The impact of all this is very rewarding. She feels better about herself, and she has had both the energy and the enthusiasm to do things that she has not done in years—developing a circle of friends, getting interested in church activities, and doing a bit of travel.

But Lacy is also struggling with a troubled relationship with a man. In fact, her drinking was, in part, an ineffective way of avoiding the problems in the relationship. She knows that she no longer wants to tolerate the psychological abuse she has been getting from her male friend, but she's afraid of the vacuum she will create by cutting off the relationship. She is, therefore, trying to determine what she wants, but she fears that ending the relationship might turn out to be the best option.

She has attempted to manage the relationship in a number of ways. For instance, she has become much more assertive with her friend. She now cuts off contact whenever he becomes abusive. And she no longer lets him make all the decisions about what they are going to do together. But the relationship remains troubled. Even though she is doing many things, there is no satisfactory outcome. She has not yet determined what the outcome should be; that is, she has not determined what

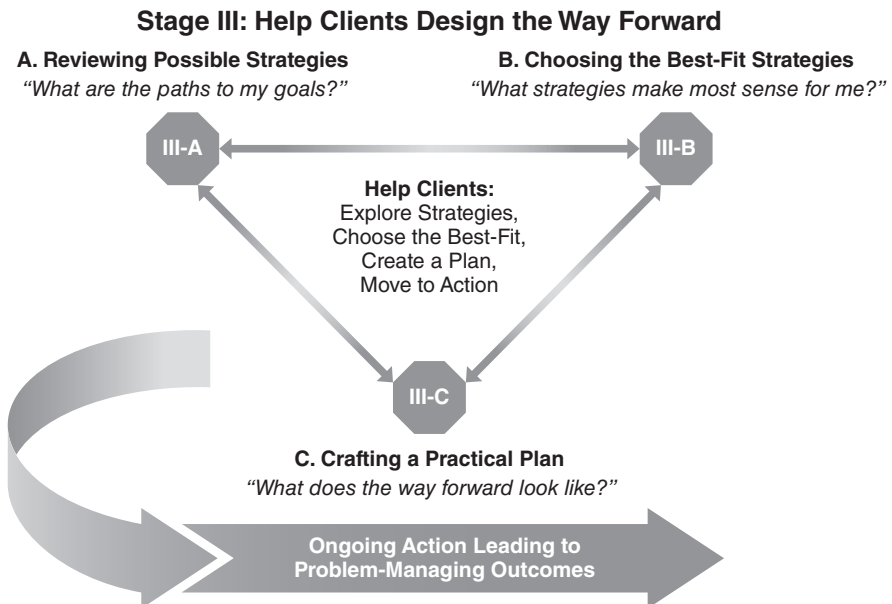
kind of relationship she would like and if it is possible to have such a relationship with this man. Nor has she determined to end the relationship.

Finally, after one seriously abusive episode, she tells him that she is ending the relationship. She does what she has to do to sever all ties with him (action), and the outcome is that the relationship ends permanently. The impact is that she feels liberated but lonely. The helping process needs to be recycled to help her with this new problem.

Stage III has three interrelated tasks. They are all aimed at problem-managing *action* on the part of the client.

- **III-A: Possible strategies.** Help clients develop possible strategies for accomplishing their goals. “What kind of actions will help me get what I need and want?”
- **III-B: Best-fit strategies.** Help clients choose strategies that are effective, efficient, and tailored to their preferences and resources. “What actions are best for me?”
- **III-C: Plans.** Help clients turn strategies into a realistic plan. “What should my campaign for constructive change look like? What do I need to do first? Second? When should I start?”

Stage III, highlighted in Figure 11.1, deals with the “game plan.” However, these three tasks constitute planning for action and should not be confused with action itself. Without action, a program for constructive change is nothing more than a wish list.



**FIGURE 11.1**  
The Three Tasks of Stage III

## Review a Hospital Case That Highlights the Need for Stage-III Skills **LO 11.2**

Here is a case we can refer to as we review the methods and skills needed for effective planning. Remember though, planning is not the same as executing a plan. Chapter 8 outlines the methods and skills needed to move into goal-accomplishing action.

Cliff is a psychologist who works in a large hospital (let us call it Astinal) for patients with both physical and psychological disabilities. He has worked here for over 20 years. During those years he studied management and business and now is as much an internal management consultant as a therapist. He works closely with several doctors, including Claudia, the president of the not-for-profit hospital. A second client is Terrence, a cardiologist who is in charge of the operating room. A third is Andrea, a behavioral psychiatrist who heads the mental disabilities unit. Cliff is also the supervisor of five counselors who provide services for both staff and patients in the physical disabilities unit of the hospital. Andrea and two associates supervise the staff of the mental disabilities unit.

The hospital, though well regarded, has some growing pains. Perhaps more accurately, the health care industry is changing dramatically for a variety of reasons—economic, political, social, cultural, and technological, but Astinal has not grown with it. Claudia is a good manager, but probably not a leader. She keeps the place humming, but innovation is not her long suit. Of course, challenges can be very motivational, but members of the staff need to see them, at least in part, as opportunities. In terms of intake, the hospital has grown some 25 percent in the last three years, but, as some say, it is still “the same place.” It needs to become a “different place.” One recent challenge struck like an earthquake. The operating room (OR) lost its high rating. Everyone was shocked. The surgeons, including Terrence the OR head, are top notch. What’s going on? Terrence is so devastated that he has offered his resignation, even though he had no clue why the OR got a poor rating. Claudia has turned down his resignation.

Terrence contacts Cliff for help in dealing with the downgrade of the OR. Here is what they discover. Terrence says that he does not understand the downgrade because the hospital has “some of the best surgeons in the world.” However, he failed to see that this group had too much ego and too little communication competence. A little bit of research showed Cliff that most OR problems come from poor communication and poor teamwork among surgeons, anesthesiologists, nurses, and other members of the OR staff. Surgeons, because they were at the top of the positional hierarchy could ignore and even bully other members of the OR staff. Mistakes were made and patients’ needs were not being met in part because patients had become more demanding.

So this is the context. In this chapter, we will be taking a look at some of the challenges its staff was facing from the viewpoint of needed change, both institutional and individual. The hospital did not have a lot of problems like the one in the OR. It suffered mainly from ignored and unused opportunities. It had a culture of competence, but it lacked a culture of innovation.

## III-A: Help Clients Develop Strategies for Accomplishing Their Goals **LO 11.3**

Strategies are actions that help clients accomplish their goals. This chapter is important precisely because it deals with actions clients must engage in to change their lives. That’s why a bias toward action is one of the key values outlined in

Chapter 3. Task III-A, developing a range of possible strategies to accomplish goals, is an exercise in liberation. Clients who feel hemmed in by their problems and unsure of the viability of their goals are liberated by defining the way forward. Through this process. Clients who begin to see clear pathways to their goals have a greater sense of self-efficacy. “I can do this.”

Strategy is the art of identifying and choosing realistic courses of action for achieving goals and doing so under adverse conditions, such as war. The problem situations in which clients are immersed constitute adverse conditions; clients often are at war with themselves and the world around them. Helping clients develop strategies to achieve goals can be a most thoughtful, humane, and fruitful way of being with them. This step in the counseling process is another that helps sometimes avoid because it is too jargon-laden and mechanical. They do their clients a disservice. Clients with goals but no clear idea of how to accomplish them are still at sea. Once more it is a question of helping clients stimulate their imaginations and engage in divergent thinking. Most clients do not instinctively seek different routes to goals and then choose the ones that make most sense.

Claudia, the hospital’s president, poured a lot of energy into making sure that the hospital was known for its competence. She did very little about innovation. She never got to Stage III because she did not engage in a key leadership role, facilitating a steady flow of innovative ideas. CEOs do not need to come up with innovative ideas themselves, but they do need to facilitate and reward a steady flow of innovative ideas within their organizations. Cliff began working with Claudia, not to help her become the main source of innovation, but rather to help her move into the facilitator role. There were plenty of innovative ideas among those who worked in the hospital, but there was no system or culture to tap into them.

### Use Brainstorming to Help Clients Discover Strategies

Brainstorming, discussed in Chapter 10, can play an important role in developing strategies to accomplish goals. People tend to make better decisions if they have an opportunity to choose from among a number of options. Brainstorming in Stage III can run from totally focused to wild, just as it is in Stage II. Janice is a young nurse at Astinal Hospital. She graduated with honors from the nursing school at a local university. She is competent and a hard worker but slow at developing a social system outside the hospital. She has no boyfriend—“I’m just too busy.” Her lack of a social life has begun to be depressing, so she begins to have informal talks with Bella, a counselor in the psychological debilities unit. Janice’s first goal is to establish a social life beyond work. Bella offers to help her brainstorm ways of doing this, but Janice, an entrepreneur in her own way, says, “No. Give me a couple of weeks and I’ll spread out the brainstorming on my own. Then I’ll bring my list to you and you can help me work through it.” Janice keeps a pad of paper with her and writes down ideas as they come along. Here are some of the possibilities she comes up with:

- Go to select alumni events of her local alma mater.
- Get involved with the nursing school alumni association itself as a volunteer.
- Join LinkedIn and look into more tailored social networking sites.

- Attend a couple of sessions at a nondenominational church group.
- Start a part-time MBA in order to get involved with people with similar management aspirations.
- Experiment with some online “friendships.”
- Work with the volunteer group at the hospital as a way of making new friends.
- Investigate local civic clubs.
- See if there are single women’s clubs in town.
- See if there are women’s book clubs in town.
- Say yes to fellow workers who have invited her over to their houses for a meal.

Janice acted on some of these possibilities right away. Remember that the work done in any stage or task can stimulate action, often small actions, that keep the client headed in the right direction. For instance, she joined LinkedIn and contacted a couple of nurses who might be struggling with issues similar to hers. She had an interview with the head of alumni relations at her alma mater and attended one of the alumnae events. However, the main outcome from the brainstorming venture was unexpected. Janice said to Bella, “It began to seem phony to me. You know, the whole idea of creating a social life. The main thing I learned was that I am really interested in management. I like working with people, but I’m not that interested in being a ‘social’ person, if you get what I mean. The idea of getting an MBA kept popping up in my mind.” In the end, Janice “discovered” Cliff, joined his unit, and began working toward a management degree. She discovered a goal and found a way of pursuing it. Her depression disappeared.

Janice did most of this on her own. Should helpers make suggestions? Helpers may make suggestions but they have to do it in a way that keeps the client in the driver’s seat. Therapists do not make choices for clients either directly or indirectly; rather they help clients make life-enhancing decisions. There are a number of ways of doing this. There is the “prompt and fade” technique. The counselor can say, “Here are a couple of possibilities. . . . Let’s take a look at them and see whether any of them make sense to you. Or maybe they can kick start some ideas of your own.” Or, “Here are some of the things that people with this kind of problem situation have tried. . . . How do they sound to you?” The “fade” part of this technique keeps it from being advice giving. It remains clear that the client must think these strategies over, choose the right ones, and commit to them. Consider Elton.

Elton, a graduate student in counseling psychology, is plagued with perfectionism. Although he is an excellent student, he worries about getting things right. After he writes a paper or practices counseling, he agonizes over what he could have done better. The kind of behavior puts him on edge when he practices counseling with his fellow trainees. They tell him that his “edge” makes them uncomfortable and interferes with the flow of the helping process. One student says to him, “You make me feel as if I’m not doing the right things as a client.”

Elton realizes that “less is more”—that is, becoming less preoccupied with the details of helping will make him a more effective helper. His goal is to become more relaxed in the helping sessions, free his mind of the “imperatives” to be perfect, and learn from mistakes rather than expending an excessive amount of effort trying

to avoid them. He and his supervisor talk about ways he can free himself of these inhibiting imperatives.

**SUPERVISOR:** What kinds of things can you do to become more relaxed?

**ELTON:** I need to focus my attention on the client and the client's goals instead of being preoccupied with myself. I'm so focused on myself.

**SUPERVISOR:** So a basic shift in your orientation right from the beginning will help.

**ELTON:** Right. And this means getting rid of a few inhibiting beliefs.

**SUPERVISOR:** Such as. . .

**ELTON:** That technical perfection in the helping model is more important than the relationship with the client. I get lost in the details of the model and have forgotten that I'm a human being with another human being.

**SUPERVISOR:** So "re-humanizing" the helping process in your own mind will help. . . . Any other internal behaviors need changing?

**ELTON:** Another belief is that I have to be the best in the class. That's my history, at least in academic subjects. Being as effective as I can be in helping a client has nothing to do with competing with my fellow students. Competing is a distraction. I know it's in my bones. It might have been all right in high school, but. . .

**SUPERVISOR:** Okay, so the academic-game mentality doesn't work here. . . .

**ELTON (interrupting):** That's precisely it. Even the practicing we do with one another is real life, not a game. You know that a lot of us talk about real issues when we practice.

**SUPERVISOR:** You've been talking about getting your attitudes right and the impact that can have on helping sessions. What behaviors come to mind?

**ELTON (pauses):** I'm hesitating because it strikes me how I'm in my head too much, always figuring myself out. . . . On a much more practical basis, I like what Jerry and Philomena do. Before each session with their "clients" in their practice sessions, they spend 5 or 10 minutes reviewing just where the client is in the overall helping process and determining what they might do in the next session to add value and move things forward. That puts the focus where it belongs, on the client.

**SUPERVISOR:** So a mini prep for each session can help you get out of your world and into the client's.

**ELTON:** Also in debriefing the training videos we make each week. . . . I now see that I always start by looking at my behavior instead of what's happening with the client. . . . Oh, there's another thing I can do. I can share just what we've been discussing here with my training partner.

**SUPERVISOR:** I'm not sure whether you bring up the perfectionism issues when you're the "client" in the practice sessions or in the weekly lifestyle group meetings.



**ELTON (hesitating):** Well, not really. I'm just coming to realize how pervasive it is in my life. . . . To tell you the truth I think I haven't brought it up because I'd rather have my fellow trainees see me as competent, not perfectionist. . . . Well, the cat is out of the bag with you, so I guess it makes sense to put it on my lifestyle group agenda.

This dialogue, which includes empathy, probes, and invitations to self-challenge from the supervisor, produces a number of strategies that Elton can use to develop a more client-focused mentality.

### **Use a Variety of Frameworks to Stimulate Clients' Search for Strategies**

Helpers can use simple **frameworks** to formulate questions or probes that help clients develop a range of strategies. Simple frameworks can help. Consider the following case.

Jackson has terminal cancer. He has been in and out of Astinal several times over the past few months, and he knows that he probably will not live more than a year. He would like the year to be as full as possible, and yet he wants to be realistic. He hates being in the hospital, especially a large hospital, where it is so easy to be anonymous. One of his goals is to die outside the hospital. He would like to die as peacefully as possible and retain possession of his faculties as long as possible. How is he to achieve these goals?

You can use probes and prompts to help clients discover possible strategies by helping them investigate resources in their lives, including people, models, communities, places, things, organizations, programs, and personal resources.

**Individuals** What individuals might help clients achieve their goals? Jackson gets the name of a local doctor who specializes in the treatment of chronic, cancer-related pain. The doctor teaches people how to use a variety of techniques to manage pain. Jackson says that perhaps his wife and daughter can learn how to give simple injections to help him control the pain. A friend of his has mentioned that his father got excellent hospice care and died at home. Also, he thinks that talking every once in a while with a friend whose wife died of cancer, a man he respects and trusts, will help him find the courage he needs.

**Models and exemplars** Who is presently doing what the client wants to do? One of Jackson's fellow workers died of cancer at home. Jackson visited him there a couple of times. That is what gave him the idea of dying at home, or at least outside the hospital. He noticed that his friend never allowed himself to engage in poor-me talk. He refused to see dying as anything but part of living. This touched Jackson deeply at the time, and now reflecting on that experience may help him develop the same kind of upbeat attitudes.

**Communities** What communities of people are there through which clients might identify strategies for implementing their goals? Even though Jackson has not been a regular churchgoer, he does know that the parish within which he resides has some resources for helping those in need. A brief investigation reveals that the parish has developed a relatively sophisticated approach to providing

various services for the sick. He also does an Internet search and discovers that there are a number of self-help groups for people like him.

**Places** Are there particular places that might help? Jackson immediately thinks of Lourdes, the shrine to which Catholic believers flock with all sorts of human problems. He does not expect miracles, but he feels that he might experience life more deeply there. It is a bit wild, but why not a pilgrimage? He still has the time and also enough money to do it. He also finds a high-tech place—an Internet chat room for cancer patients and their caregivers. This helps him get out of himself and, at times, become a helper instead of a client.

**Things** What things can help clients achieve their goals? Jackson has read about the use of combinations of drugs to help stave off pain and the side effects of chemotherapy. He has heard that certain kinds of electric stimulation can ward off chronic pain. He reads the pain-reduction research and discusses some of the pain-reduction possibilities with his doctor and even arranges for second opinions.

**Organizations** Jackson runs across an organization that helps young cancer patients get their wishes. He volunteers. In his role as helper, he finds he receives as much help and motivation and solace as he gives.

**Programs** Are there any ready-made programs for people in the client's position? He learns that a new hospice in his part of town has three programs. One helps people who are terminally ill stay in the community as long as they can. A second makes provision for part-time residents. The third provides a residential program for those who can spend little or no time in the community. The goals of these programs are practically the same as Jackson's. Box 11.1 outlines some questions that you can help clients ask themselves to develop strategies for accomplishing goals.

### Help Clients Find Social Support in Their Efforts to Change

Planning includes helping clients identify the internal and environmental resources they need to pursue goals. One of the most important resources is social support (Barker & Pistrang, 2002; Seeman, 1996; Taylor, 2007; Taylor and associates, 2004), though, surprisingly enough, research to verify the usefulness of social support is skimpy (Cruza-Guet and associates, 2008; Hogan, Linden, & Najarian, 2002; Roehrle & Strouse, 2008), highlighting once more the necessity of common sense to outpace “science.” Most practitioners see social support as a key element in problem-managing change.

Social support has . . . been examined as a predictor of the course of mental illness. In about 75% of studies with clinically depressed patients, social-support factors increased the initial success of treatment and helped patients maintain their treatment gains. Similarly, studies of people with schizophrenia or alcoholism revealed that higher levels of social support are correlated with fewer relapses, less frequent hospitalizations, and success and maintenance of treatment gains. (Basic Behavioral Science Task Force of the National Advisory Mental Health Council, 1996, p. 628)

**BOX 11.1**      **Questions for Developing Strategies**

Here are the kinds of questions you can help clients ask themselves in their search for ways of accomplishing their goals.

- Now that I know what I want, what do I need to do?
- Now that I know my destination, what are the different routes for getting there?
- What actions will get me to where I want to go?
- Now that I know the gaps between what I have and what I want and need, what do I need to do to bridge those gaps? How many ways are there to accomplish my goals?
- How do I get started?
- What can I do right away?
- What do I need to do later?

While helpers themselves can provide a great deal of support, still, if clients are to pursue goals “out there” in their real lives, their main support should also be out there. Unfortunately, such support may not always be easy to find (Putnam, 2000). In North American society, the supply of “social capital”—both informal social connectedness and formal civic engagement—has fallen. We belong to fewer organizations that conduct meetings, know our neighbors less, meet with friends less frequently, and even socialize with our families less often. Yet this is the environment in which clients must do the work of constructive change. Being active in the social media does not seem to be a good substitute.

In a study on weight loss and maintaining the loss (Wing & Jeffery, 1999), clients who enlisted the help of friends were much more successful than clients who took the solo path. This is called “**social facilitation**” and is quite different from dependence. Social facilitation is energizing, whereas dependence is often depressing. Therefore a culture of social isolation does not bode well for clients. Of course, all of this reinforces what we already know through common sense. Who among us has not been helped through difficult times by family and friends?

When it comes to social support, there are two categories of clients. First, there are those who lead an impoverished social life. The objective with this group is to help them find social resources, to get back into community in some productive way. But what about clients who do have people they can turn to? Well, as Putnam points out, even when clients, at least on paper, have a social system, they may not use it very effectively. This provides counselors with a different challenge—that is, helping clients tap into those human resources in a way that helps them manage problem situations more effectively. Consider this example.

Casey, a bachelor whose job involved frequent travel literally around the world, fell ill. He had many friends, but they were spread around the world. Because he was neither married nor in a marriage-like relationship, he had no primary caregiver

in his life. He received excellent medical care, but his psyche fared poorly. Once out of the hospital, he recuperated slowly, mainly because he was not getting the social support he needed. In desperation, he had a few sessions with a counselor, sessions that proved to be quite helpful. The counselor challenged him to “ask for help” from his local friends. He had underplayed his illness with them because he didn’t want to be a “burden.” He discovered that his friends were more than ready to help. But because their time was limited, he, with some hesitancy, “grafted” onto his rather sparse hometown social network some very caring people from the local church. He was fearful that he would be deluged with piety, but instead he found people like himself. Moreover, they were, in the main, socially intelligent. They knew how much or how little care to give. In fact, most of the time their care was simple friendship.

Casey was likeable. What about those who are less likeable? The National Advisory Mental Health Council study just mentioned showed that people who are highly distressed and therefore most in need of social support may be the least likely to receive it because their expressions of distress drive away potential supporters. Who among us has not avoided at one time or another a distressed friend or colleague? Therefore distressed clients can be helped to learn how to modulate their expressions of distress. Who wants to help whiners? On the other hand, potential supporters can learn how to deal with distressed friends and colleagues, even when these friends and colleagues let themselves become whiners.

Claudia, the hospital president, is a bit shaken as she wonders whether she is “just” a decent manager but not yet a leader. Cliff not only helps her wrestle with issues such as this, but also provides social support. His therapeutic skills, his supervisory experience, his consultancy skills, and his deep understanding of the hospital, its history, its culture, and even its shadow side combined with his nonthreatening style of coaching, provide Claudia with a great deal of support.

Eventually, all clients have to make it without the help of a counselor. Therefore effective helpers right from the beginning try to help them explore the social-support dimensions of problem situations. At the Action Arrow stage, questions like the following are appropriate: Who might help you do this? Who’s going to encourage or even challenge you when you want to give up? With whom can you share these kinds of concerns? Who’s going to give you a pat on the back when you accomplish your goal?

### **Help Clients Determine the Skills Needed to Move Forward**

People often get into trouble or fail to get out of it because they lack the needed life skills or coping skills to deal with problem situations. When this is the case, helping clients find ways of learning the life skills they need to cope more effectively is an important broad strategy. Indeed, the use of skills training as part of therapy—what Carkhuff years ago (1971) called “training as treatment”—might be essential for some clients. Challenging clients to engage in activities for which they do not have the skills compounds, rather than solves the problem. What kinds of working knowledge and skills does this client need to get where he or she wants to go? Consider the following case.

Jerzy and Zelda fell in love. They married and enjoyed a relatively trouble-free honeymoon period of about two years. Eventually, however, the problems that

inevitably arise from living closely together asserted themselves. For instance, they found that they counted too heavily on romantic fervor to help them overcome—or, more often, ignore—difficulties. Once that fervor had cooled, they began fighting about finances, sex, and values. They lacked certain critical interpersonal communication skills. Furthermore, their nine-year age difference became problematic because they lacked understanding of each other's developmental needs. Jerzy had little working knowledge of the developmental demands of a 20-year-old woman; Zelda had little working knowledge of the kinds of cultural blueprints that were operative in the lifestyle of her 29-year-old husband. The relationship began to deteriorate. Because they had few problem-solving skills, they didn't know how to handle their situation.

Jerzy and Zelda needed both working knowledge and skills. This is hardly surprising. Lack of requisite interpersonal communication and other life skills is often at the heart of relationship breakdowns.

One marriage counselor I know does marriage counseling in groups of four couples. Training in communication skills is part of the process. He separates men from women and trains them in tuning in, active listening, and responding with empathy. For skills practice, he begins by pairing a woman with a woman and a man with a man. Next he pairs a man and a woman, but not spouses. Finally, spouses are paired, taught a simple version of the problem-management process outlined in this book, and then helped to use the skills they have learned to engage in problem solving with each other. In sum, he equips them in two sets of life skills—interpersonal communication and problem solving.

### Help Clients Use Possible Strategies as Links to Action

Some clients are filled with great ideas for getting things done but never seem to do anything. They lack the discipline to evaluate their ideas, choose the best, and turn them into action. Often this kind of work seems too tedious to them, even though it is precisely what they need. Consider the following case.

Clint came away from the doctor feeling depressed. He was told that he was in the high-risk category for heart disease and that he needed to change his lifestyle. He was cynical, very quick to anger, and did not readily trust others. Venting his suspicions and hostility did not make them go away, however; it only intensified them. Therefore one critical lifestyle change was to change this pattern and develop the ability to trust others.

He developed three broad goals: reducing mistrust of others' motives, reducing the frequency and intensity of such emotions as rage, anger, and irritation, and learning how to treat others with consideration. Clint read through the common strategies used to help people pursue these broad goals (see Williams, 1989). They included the following:

- Keeping a hostility log to discover the patterns of cynicism and irritation in one's life
- Finding someone to talk to about the problem, someone to trust
- "Thought stopping," catching oneself in the act of indulging in hostile thoughts or in thoughts that lead to hostile feelings
- Talking sense to oneself when tempted to put others down
- Developing empathic thought patterns—that is, walking in the other person's shoes

- Learning to laugh at one's own silliness
- Using a variety of relaxation techniques, especially to counter negative thoughts
- Finding ways of practicing trust
- Developing active listening skills
- Engaging in assertive rather than aggressive behavior
- Putting things in context, seeing each day as one's last or contrasting the seriousness of one's problems with those of people with real, life-limiting problems
- Practicing forgiving others without being patronizing or condescending

Clint prided himself on his rationality (though his “rationality” was one of the things that got him into trouble). So, as he read down the list, he chose strategies that could form an “experiment,” as he put it. He decided to talk to a counselor (for the sake of objectivity), keep a hostility log (data gathering), and use the tactics of thought stopping and talking sense to himself whenever he felt that he was letting others get under his skin. The counselor noted to himself that none of these necessarily involved changing Clint's attitudes toward others. However, he did not invite Clint to challenge himself at this point. His best bet was that through “strategy sampling” Clint would learn more about his problem, that he would find that it went deeper than he thought. Clint set himself to his experiment with vigor.

Clint chose strategies that fit his values. The problem was that the values themselves needed reviewing. But Clint did act, and action gave him the opportunity to learn.

### III-B: Help Clients Choose Best-Fit Problem-Managing Strategies **LO 11.4**

In Task III-B, clients are in decision-making mode—with all its pitfalls and promises—once more. After brainstorming strategies for accomplishing goals, they need to choose a strategy or a “package” of strategies that best fits their situation, resources, personality, and preferences and turn them into some kind of plan for constructive change. Whether these tasks are done with the kind of formality outlined here is not the point. Counselors, understanding what planning is and what makes it work, can add value by helping clients find ways of accomplishing goals (getting what they need and want) in a systematic, flexible, personalized, and cost-effective way.

Once they are helped to develop a range of strategies to implement goals, some clients move forward on their own; that is, they choose the best strategies, put together an action plan, and implement it. Others, however, need help in choosing strategies that best fit their situation, and so we add Task III-B to the helping process. It is useless to have clients brainstorm if they do not know what to do with the action strategies they generate.

#### **Learn Something about Choosing Strategies from Bud's Amazing Design-Thinking Odyssey**

Let us start with Bud, a man who was helped to discover two best-fit strategies for achieving emotional stability in his life. With these, he achieved outcomes that surpassed anyone's wildest expectations.

One morning, Bud, then 18-years-old, woke up unable to speak or move. He was taken to a hospital, where catatonic schizophrenia was diagnosed. After repeated admissions to hospitals, where he underwent both drug and electroconvulsive therapy (ECT), his diagnosis was changed to paranoid schizophrenia. He was considered incurable.

A quick overview of Bud's earlier years suggests that much of his emotional distress was caused by unmanaged life problems and the lack of human support. He was separated from his mother for four years when he was young. They were reunited in a city new to both of them, and there he suffered a great deal of harassment at school because of his "ethnic" looks and accent. There was simply too much stress and change in his life. He protected himself by withdrawing. He was flooded with feelings of loss, fear, rage, and abandonment. Even small changes became intolerable. His catatonic attack occurred in the autumn on the day of the change from daylight saving to standard time. It seemed that this ordinary change was the last straw.

In the hospital, Bud became convinced that he and many of his fellow patients could do something about their illnesses. They did not have to be victims of their own helplessness or of the institutions designed to help them. Reflecting on his hospital stays and the drug and ECT treatments, he later said he found his "help" so debilitating that it was no wonder that he got crazier. Somehow Bud, using his own inner resources, managed to get out of the hospital. Eventually, he got a job, found a partner, and got married.

One day, after a series of problems with his family and at work, Bud felt himself becoming agitated and thought he was choking to death. His doctor sent him to the hospital "for more treatment." There Bud had the good fortune to meet Sandra, a psychiatric social worker who was convinced that many of the hospital's patients were there because of lack of support before, during, and after their bouts of illness. She helped him see his need for social support, especially during times of stress. She also discovered in her inpatient counseling groups that Bud had a knack for helping others. Bud's broad goal was still emotional stability, and he wanted to do whatever was necessary to achieve it. Finding support and helping others cope with their problems, instrumental goals, were his best strategies for achieving the stability he wanted.

Once discharged from the hospital, Bud got to work. He enrolled Sandra to coach his wife on the best ways to provide support for him at times of stress. He then started a self-help group for ex-patients like himself. In the group, he was a full-fledged participant. But because he also had a deep desire to help others like himself, he developed the self-help group into a network of self-help groups for ex-patients.

This is an amazing example of a client who focused on one broad goal, emotional stability; translated it into a number of immediate, practical goals; discovered two broad strategies—finding ongoing emotional support and helping others—for accomplishing those goals; translated the strategies into practical applications; and by doing all that found the emotional stability he was looking for. Bud's case is hardly the norm, but it does highlight the power of problem management coupled with a clear sense of self-responsibility.

### **Use Criteria for Choosing Goal-Accomplishing Strategies**

The criteria for choosing goal-accomplishing strategies are like the criteria for choosing goals outlined in Stage II. These criteria are reviewed briefly here through a number of examples. Strategies to achieve goals should be, like goals



themselves, specific, robust, prudent, realistic, sustainable, flexible, cost-effective, and in keeping with the client's values. The client does not need to know all of this, though it might help, but you do. Let us take a look at a few of these criteria as applied to choosing strategies.

**Specific strategies** Strategies for achieving goals should be specific enough to drive behavior. In the preceding example, Bud's two broad strategies for achieving emotional stability, tapping into human support and helping others, were translated into quite specific strategies—keeping in touch with Sandra, getting help from his wife, participating in a self-help group, starting a self-help group, and founding and running a self-help organization. Contrast Bud's case with Stacy's.

Stacy was admitted to a mental hospital because she had been exhibiting bizarre behavior in her neighborhood. She dressed in a slovenly way and went around admonishing the residents of the community for their "sins." Her condition was diagnosed as schizophrenia, simple type. She had been living alone for about 5 years, since the death of her husband. It seems that she had become more and more alienated from herself and others. In the hospital, medication helped control some of her symptoms. She stopped admonishing others and took reasonable care of herself, but she was still quite withdrawn. She was assigned to "milieu" therapy, a euphemism meaning that she was helped to follow the more or less general routine of the hospital—a bit of work, a bit of exercise, some programmed opportunities for socializing. She remained withdrawn and usually seemed moderately depressed. No therapeutic goals had been set, and the nonspecific program to which she was assigned was totally inadequate.

So-called milieu therapy did nothing for Stacy because in no way was it specific to her needs. It was a general program that was only marginally better than drug-focused standard care. Bud's strategies, on the other hand, proved to be powerful. They not only helped him gain stability but also gave him a new perspective on life.

**Substantive strategies** Strategies are substantive to the degree that they challenge the client's resources and, when implemented, actually achieve the goal. Not only was Stacy's program too general, but it also lacked bite. Bud's self-chosen strategies, on the other hand, were substantive, especially the strategy of starting and running a self-help organization. What could be done for Stacy?

A newly hired psychiatrist saw immediately that Stacy needed more than either standard psychiatric or milieu-centered care. He involved her in a new comprehensive social-learning program, which included cognitive restructuring, social-skills training, and behavioral-change interventions based on incentives, shaping, modeling, and rewards. Despite a few ups and downs, Stacy responded very well to the new rather intensive program. She was discharged within six months and, with the help of an outpatient extension of the program, remained in the community.

For Stacy this program proved to be specific, substantive, prudent, realistic, sustainable, flexible, cost-effective, and in keeping with her values. It was cost-effective in two ways. First, it was the best use of Stacy's time, energy, and psychological

resources. Second, it helped her and others like her to get back into the community and stay there. It was in keeping with her values because, even though some staff members at the hospital had concluded that all she wanted was “to be left alone,” Stacy deep down valued human companionship and freedom. She did better in a community setting.

**Realistic strategies** When clients choose strategies that are beyond their resources, they are doing themselves in. Strategies are realistic when they can be carried out with the resources the client has, are under the client's control, and are unencumbered by obstacles. Bud's strategies would have appeared unrealistic to most clients and helpers. But this highlights an important point. Just as we should invite clients to review stretch goals in their search for life-enhancing outcomes, so we should not underestimate what actions clients are capable of taking to move beyond their problem situations. In the following case, Desmond moves from unrealistic to realistic strategies for getting what he wants.

Desmond was in a halfway house after leaving a state mental hospital. From time to time he still had bouts of depression that would incapacitate him for a few days. He wanted to get a job because he thought that it would help him feel better about himself, become more independent, and manage his depression better. He applied for jobs in a rather random way and was constantly turned down after being interviewed. He simply did not yet have the kinds of resources needed to put himself in a favorable light in job interviews. Moreover, he was not yet ready for a regular, full-time job.

On his own, Desmond does not do well in choosing strategies to achieve even modest goals. But here's what happened next.

A local university received funds to provide outreach services to halfway houses in the metropolitan area. The university program included finding companies that were willing, on a win-win basis, to work with halfway-house residents. A counselor from the program helped Desmond get in contact with companies that had specific programs to help people with psychiatric problems. He found two that he thought would fit his needs. Some of the best workers in these companies had a variety of disabilities, including psychiatric problems. After a few interviews, Desmond got a job in one of these companies that fitted his situation and capabilities. The entire work culture was designed to provide the kind of support he needed.

Of course, there is a difference between realism and allowing clients to sell themselves short. Substantive strategies that make clients stretch for a valued goal can be most rewarding. Bud's case is an exceptional example of that.

**Strategies in keeping with the client's values** Make sure that the strategies chosen are consistent with the client's values. Let us return to the case of the priest who had been unjustly accused of child molestation.

In preparing for the court case, the priest and his lawyer had a number of discussions. The lawyer wanted to do everything possible to destroy the accusers' credibility. He had dug into their pasts and dredged up some dirt. The priest objected to these tactics. “If I let you do this,” he said, “I descend to their level. I can't do that.” The priest discussed this with his counselor, his superiors, and another lawyer. He

stuck to his guns. They prepared as strong a case as possible, but one based on facts without any sleaze.

After the trial was over and he was acquitted, the priest said that his discussion about the lawyer's preferred tactics was one of the most difficult issues he had to face. Something in him said that because he was innocent, any means to prove his innocence was allowed. Something else told him that this was not right. The counselor helped him clarify and challenge his values but made no attempt to impose either his own or the lawyer's values on his client.

What do helpers do if their values differ significantly from the values of a client? See what the APA and the ACA have to say about this.

### **Use Strategy Sampling as a Way of Getting the Right Package**

Some clients find it easier to choose strategies when they first sample some of the possibilities. Consider this case.

Two business partners were in conflict over ownership of the firm's assets. Their goals were to see justice done, to preserve the business, and, if possible, to preserve their relationship. A colleague helped them sample some possibilities. Under her guidance, they discussed with a lawyer the process and consequences of bringing their dispute to the courts, they had a meeting with a consultant-counselor who specialized in these kinds of disputes, and they visited an arbitration firm.

In this case, the sampling procedure had the added effect of giving them time to let their emotions simmer down. They agreed to go the consultant-counselor route.

Of course, some clients could use strategy sampling as a way of putting off action. That was certainly not the case with Bud. His attending the meeting of a self-help group after leaving the hospital was a form of strategy sampling. Although the group impressed him, he thought that he could start a group limited to ex-patients that would focus more directly on the kinds of issues he and other ex-patients were facing. As we have seen earlier, Mara instinctively moves into strategy sampling after her brainstorming. She finds that she is much more ready to explore than she might have imagined.

### **Follow the Balance-Sheet Method for Choosing Strategies**

Some form of balance sheet can be used to help clients make decisions in general. The methodology could be used for any key decision related to the helping process—whether to get help in the first place, to work on one problem rather than another, or to choose this rather than that goal. Balance sheets deal with the acceptability and unacceptability of both benefits and costs. A balance-sheet approach, applied to choosing strategies for achieving goals, poses questions such as the following:

- What are the benefits of choosing this strategy? For myself? For significant others?
- To what degree are these benefits acceptable? To me? To significant others?
- In what ways are these benefits unacceptable? To me? To significant others?
- What are the costs of choosing this strategy? For myself? For significant others?

- To what degree are these costs acceptable? To me? To significant others?
- In what ways are these costs unacceptable? To me? To significant others?

Let us return to Karen. She used the balance-sheet method to assess the viability, not of a goal, but of strategies to achieve a goal. Karen's goal was to stop drinking. One possible strategy for accomplishing that goal was to spend a month as an inpatient at an alcoholic treatment center. This possibility appealed to her. However, because choosing this strategy would be a serious decision, the counselor, Joan, helped Karen use the balance sheet to weigh possible costs and benefits. After filling it out, Karen and Joan discussed Karen's findings. She chose to consider the pluses and minuses for herself and for her husband and children. Karen concludes, "All in all, it seems like the residential program is a good idea. There is something much more substantial about it than an outpatient program. But that's also what scares me."

Now, let us look at a more practical and flexible approach to using the balance sheet. It is not to be used with every client to work out the pros and cons of every course of action. Tailor the balance sheet to the needs of the client. Choose the parts of the balance sheet that will add most value with this client pursuing this goal or set of goals. In fact, one of the best uses of the balance sheet is not to use it directly at all. Keep it in the back of your mind whenever clients are making decisions. Use it as a filter to listen to clients. Then turn relevant parts of it into probes to help clients focus on issues they may be overlooking. "How will this decision affect the significant people in your life?" is a probe that originates in the balance sheet. "Is there any downside to that strategy?" might help a client who is being a bit too optimistic. No formula. Box 11.2 outlines the kinds of questions you can help clients ask themselves in order to choose best-fit strategies.

### Be Aware of the Shadow Side of Strategy Selection

The shadow side of decision-making is certainly at work in clients' choosing strategies to implement goals. Early on Goslin (1985, pp. 7, 9) described pitfalls in decision making that subsequent research has proved to be all too prevalent.

#### BOX 11.2 Questions on Best-Fit Strategies

Here are some questions you can help clients ask themselves to determine which strategies will best fit their situation.

- Which strategies will be most useful in helping me get what I need and want?
- Which strategies are best for this situation?
- Which strategies best fit my resources?
- Which strategies will be most economical in the use of resources?
- Which strategies are most powerful?
- Which strategies best fit my preferred way of acting?
- Which strategies best fit my values?
- Which strategies will have the fewest unwanted consequences?

In defining a problem, people dislike thinking about unpleasant eventualities, have difficulty in assigning . . . values to alternative courses of action, have a tendency toward premature closure, overlook or undervalue long-range consequences, and are unduly influenced by the first formulation of the problem. In evaluating the consequences of alternatives, they attach extra weight to those risks that can be known with certainty. They are more subject to manipulation . . . when their own values are poorly thought through. . . . A major problem for individuals is knowing when to search for additional information relevant to decisions.

In choosing a course of action, clients often fail to evaluate the risks involved and determine whether the risk is balanced by the probability of success. Gelatt, Varenhorst, and Carey (1972) suggested four ways in which clients may try to deal with the factors of risk and probability: wishful thinking, playing it safe, avoiding the worst outcome, and achieving some kind of balance. The first three are often pursued without reflection and therefore lie in the “shadows.”

***Wishful thinking*** In this case, clients choose a course of action that might (they hope) lead to the accomplishment of a goal regardless of risk, cost, or probability. For instance, Jenny wants her ex-husband to increase the amount of support he is paying for the children. She tries to accomplish this by constantly nagging him and trying to make him feel guilty. She doesn’t consider the risk (he might get angry and stop giving her anything), the cost (she spends a great deal of time and emotional energy arguing with him), or the probability of success (he does not react favorably to nagging). The wishful-thinking client operates blindly, engaging in some course of action without taking into account its usefulness. At its worst, this is a reckless approach. Clients who “work hard” and still “get nowhere” may be engaged in wishful thinking, persevering in using means they prefer but that are of doubtful efficacy. Effective helpers find ways of challenging wishful thinking. “Jenny, it might be useful to review what you’ve been doing to get Tom to pay up and how successful you’ve been.”

***Playing it safe*** In this case, the client chooses only safe courses of action, ones that have little risk and a high degree of probability of producing at least limited success. For instance, Liam, a manager in his early 40s, is very dissatisfied with the way his boss treats him at work. His ideas are ignored, the delegation he is supposed to have is preempted, and his boss does not respond to his attempts to discuss career development. His goals center on his career. He wants to let his boss know about his dissatisfaction and he wants to learn what his boss thinks about him and his career possibilities. These are instrumental goals, of course, because his overall goal is to carve out a more promising career path. However, he fails to bring these issues up when his boss is “out of sorts.” On the other hand, when things are going well, Liam doesn’t want to “upset the applecart.” He drops hints about his dissatisfaction, even joking about them at times. He tells others in hopes that word will filter back to his boss. During formal appraisal sessions he allows himself to be intimidated by his boss. However, in his own mind, he is doing whatever could be expected of a “reasonable” man. He does not know how safe he is playing it. What might you say to Liam at this juncture?

***Avoiding the worst outcome*** In this case, clients choose means that are likely to help them avoid the worst possible result. They try to minimize the maximum danger, often without identifying what that danger is. Crissy, dissatisfied with

her marriage, sets a goal to be “more assertive.” However, even though she has never said this either to herself or to her counselor, the maximum danger for her is to lose her partner. Therefore her “assertiveness” is her usual pattern of compliance, with some frills. For instance, every once in a while she tells her husband that she is going out with friends and will not be around for supper. Without her knowing it, he actually enjoys these breaks. At some level of her being, she realizes that her absences are not putting him under any pressure, but she continues to be “assertive” in the same way. She never sits down with her husband to review where they stand with each other because that might be the beginning of the end. At the beginning of one session, the counselor says, “What if some good friend were to say to you, ‘Bill has you just where he wants you.’ How would you react?” Crissy is startled, but she comes away from the session with a much more realistic view of what her strategy is achieving—or not achieving.

**Striking a balance** In the ideal case, clients choose strategies for achieving goals that balance risks against the probability of success. This “combination” approach is the most difficult to apply, for it involves the right kind of analysis of problem situations and opportunities, choosing goals with the right edge, being clear about one’s values, ranking a variety of strategies according to these values, and estimating how effective any given course of action might be. Even more to the point, it demands challenging the blind spots that might distort these activities. Some, perhaps most, clients have neither the skills nor the will for this combination approach. How would you step in?

Terrence, the OR director at Astinal Health Care Center, with Cliff’s help, explores the low-rating OR problem. They come up with a number of things they can do to increase the effectiveness and efficiency of the OR. However, in reviewing the research on OR problems, they realize that Astinal suffers one of the most common problems with operating room—the lack of teamwork (Attri et al., 2015; Hull & Sevdalis, 2015; Plaza, 2016). “Approximately 50% of hospital errors occur in the operating room or in the Resuscitation suites” (Plaza, 2016, p. 1). High on the list is a lack of teamwork between the surgeon and the anesthesiologist, but there are also other players on the OR team such as nurses and technicians. Patients need a team that is centered on their needs. Terrence is hesitant in focusing on a “psychological” approach to managing the problem situation, but, again with Cliff’s help, discovers a number of highly rated team development programs that focus on hospitals in general and the OR specifically (Amaya-Arias, Idarraga, Giraldo, & Gomez, 2015). Terrence gets right on to selling the teamwork approach to surgeons and staff. He and Cliff review available programs and choose one for Astinal.

### III-C: Help Clients Turn Strategies into Viable Plans **LO 11.5**

The logic is this. After identifying and choosing strategies to accomplish goals, clients need to organize these strategies into a plan. In this task, counselors help clients come up with the plan itself, that is, the sequence of actions—what should I do first, second, and so forth—to turn the goal into an outcome. However, the execution of



these tasks—and all the tasks of the problem-management process—is often much messier. Therapists need to understand where their clients are in the geography of helping, and what they are struggling with in order to know how to intervene.

### Evaluate the Case of Frank: No Plan of Action

The lack of a plan—that is, a clear step-by-step process to accomplish a goal—keeps some clients mired in their problem situations. Consider the case of Frank, a vice president of a large West Coast corporation.

Frank was a go-getter. He was very astute about business and had risen quickly through the ranks. Vince, the president of the company, was in the process of working out his own retirement plans. From a business point of view, Frank was the heir apparent. But there was a glitch. Vince was far more than a good manager; he was a leader. He had a vision of what the company should look like 5 to 10 years down the line. Early on, he saw the power of the Internet and used it wisely to give the business a competitive edge.

Though tough, Vince related well to people. People constituted the human capital of the company. He knew that products and people kept customers happy. He also took to heart the results of a millennium survey of some two million employees in the United States. One of the sentences in the summary of the survey results haunted him—“People join companies but leave supervisors.” In the “war for talent,” he couldn’t afford supervisors who alienated their team members.

Frank was quite different. He was a “hands-on” manager, meaning, in his case, that he was slow to delegate tasks to others, however competent they might be. He kept second-guessing others when he did delegate, reversed their decisions in a way that made them feel put down, listened poorly, and took a fairly short-term view of the business—“What were last week’s figures like?” He was not a leader but an “operations” man. His direct reports called him a micromanager.

One day, Vince sat down with Frank and told him that he was considering him as his successor down the line, but that he had some concerns. “Frank, if it were just a question of business acumen, you could take over today. But my job, at least in my mind, demands a leader.” Vince went on to explain what he meant by a leader and to point out the things in Frank’s style that had to change.

So Frank did something that he never thought we would do. He began seeing a coach. Roseanne had been an executive with another company in the same industry but had opted to be a consultant for family reasons. Frank chose her because he trusted her business acumen. That’s what meant most to him. They worked together for over a year, often over lunch and in hurried meetings early in the morning or late in the evening. And, indeed, he valued their dialogues about the business.

Frank’s ultimate aim was to become president. If getting the job meant that he had to try to become the kind of leader his boss had outlined, so be it. Because he was very bright, he came up with some inventive strategies for moving in that direction. But he could never be pinned down to an overall program with specific milestones by which he could evaluate his progress. Roseanne pushed him, but Frank was always “too busy” or would say that a formal program was “too stifling.” That was odd, because formal planning was one of his strengths in the business world.

Frank remained as astute as ever in his business dealings. But he merely dabbled in the strategies meant to help him become the kind of leader Vince wanted him to be. Frank had the opportunity of not just correcting some mistakes, but also developing and expanding his managerial style. But he blew it. At the end of 2 years, Vince appointed someone else president of the company.



Frank never got his act together. He never put together the kind of change program needed to become the kind of leader Vince wanted as president. Why? Frank had two significant blind spots that the consultant did not help him overcome. First, he never really took Vince's notion of leadership seriously. So he wasn't really ready for a change program. He thought the president's job was his and that business acumen alone would win out in the end. Second, he thought he could change his management style at the margins, even though more substantial changes were called for.

Roseanne never challenged Frank as he kept "trying things" that never led anywhere. Maybe things would have been different if she had said something like, "Come on, Frank, you know you do not really buy Vince's notion of leadership. But you can't just give lip service to it. Vince will see right through it. We're just messing around. You do not want a program because you do not believe in the goal. Let us do something or call these meetings off." If she had challenged him like this, Frank probably would have said, "I think I need a different consultant." In a way she was a coconspirator because she, too, relished their business discussions. When Frank didn't get the job, he left the company, leaving Roseanne to ponder her success as a consultant but her failure as a coach.

### **Understand How Plans Add Value to Clients' Change Programs**

Some clients, once they know what they want and some of the things they have to do to get what they want get their act together, develop a plan, and move forward. Other clients need help. Because some clients (and some helpers) fail to appreciate the power of a plan, it is useful to start by reviewing the advantages of planning.

Not all plans are formal. "Little plans," whether called such or not, are formulated and executed throughout the helping process. Tess, an alcoholic who wants to stop drinking, feels the need for some support. She contacts Lou, a friend who has shaken a drug habit, tells him of her plight, and enlists his help. He readily agrees. Objective accomplished. This "little plan" is part of her overall change program. Change programs are filled with setting "little objectives" and developing and executing "little plans" to achieve them.

Formal planning usually focuses on the sequence of the "big steps" clients must take in order to get what they need or want. Clients are helped to answer the question, "What do I need to do first, second, and third?" A formal plan in its most formal version takes strategies for accomplishing goals, divides them into workable steps, puts the steps in order, and assigns a timetable for the accomplishment of each step. Formal planning, provided that it is adapted to the needs of individual clients, has a number of advantages.

***Plans help clients develop needed discipline*** Many clients get into trouble in the first place because they lack discipline. Planning places reasonable demands on clients to develop discipline. Desmond, the halfway-house resident discussed earlier in this chapter, needed discipline and benefited greatly from a formal job-seeking program. Indeed, ready-made programs such as the 12-step program of Alcoholics Anonymous are in themselves plans that demand or at least encourage self-discipline.

***Plans keep clients from being overwhelmed*** Plans help clients see goals as doable. They keep the steps toward the accomplishment of a goal “bite-size.” Amazing things can be accomplished by taking bite-size steps toward substantial goals. Bud, the ex-psychiatric patient who ended up creating a network of self-help groups for ex-patients, started with the bite-size step of participating in one of those groups himself. He did not become a self-help entrepreneur overnight. It was a step-by-step process that proved to be messy at times—two steps forward and one back.

***Formulating plans helps clients search for more useful ways of accomplishing goals—that is, even better strategies*** Sy Johnson was an alcoholic. When Mr. Johnson’s wife and children, working with a counselor, began to formulate a plan for coping with their reactions to his alcoholism, they realized that the strategies they had been trying were hit-or-miss. With the help of an Al-Anon self-help group, they went back to the drawing board. Mr. Johnson’s drinking had introduced a great deal of disorder into the family. Planning would help them restore order.

***Plans provide an opportunity to evaluate the realism and adequacy of goals*** This is an example of the “dialogue” that should take place among the stages of the helping process. When Walter, a middle manager who had many problems in the workplace, began tracing out a plan to cope with the loss of his job and with a lawsuit filed against him by his former employer, he realized that his initial goals—getting his job back and filing and winning a countersuit—were unrealistic. His revised goals included getting his former employer to withdraw the suit and getting into better shape to search for a job by participating in a self-help group of managers who had lost their jobs.

***Plans make clients aware of the resources they will need to implement their strategies*** When Dora was helped by a counselor to formulate a plan to pull her life together after the disappearance of her younger son, she realized that she lacked the social support needed to carry out the plan. She had retreated from friends and even relatives, but now she knew she had to get back into community. Normalizing life demanded ongoing social involvement and support. A goal of finding the support needed to get back into community was added to her constructive-change program.

***Formulating plans helps clients uncover unanticipated obstacles to the accomplishment of goals*** Ernesto, a U.S. soldier who had accidentally killed an innocent bystander during his stint in Afghanistan, was seeing a counselor because of the difficulty he was having returning to civilian life. Only when he began pulling together and trying out plans for normalizing his social life did he realize how ashamed he was of what had happened to him in the military. He felt so flawed because of it that it was almost impossible to involve himself intimately with others. Helping him deal with his shame became one of the most important parts of the healing process.

Formulating plans will not solve all our clients’ problems, but it is one way of making time an ally instead of an enemy. Many clients engage in aimless

activity in their efforts to cope with problem situations. Plans help clients make the best use of their time. Finally, planning itself has a hefty shadow side. For a good review of the shadow side of planning, see Dorner (1996, pp. 153–183).

## Review Two Approaches to Shaping the Plan

Plans need “shape” to drive action. A formal plan identifies the activities or actions needed to accomplish a goal or a subgoal, puts those activities into a logical but flexible order, and sets a time frame for the accomplishment of each key step. Therefore a plan should include the answers to these three simple questions.

- What are the concrete things that need to be done to accomplish the goal or the subgoal?
- In what sequence should these be done? What should be done first, what second, what third?
- What is the time frame? What should be done today, tomorrow, next month?

If clients choose goals that are complex or difficult, then it is useful to help them establish subgoals as a way of moving step-by-step toward the ultimate goal. For instance, once Bud decided to start an organization of self-help groups composed of ex-patients from mental hospitals, there were a number of subgoals he needed to accomplish before the organization would become a reality. His first step was to set up a test group. This instrumental goal provided the experience needed for further planning. A later step was to establish some kind of charter for the organization. “Charter in place” was one of the subgoals leading to his main goal.

In general, the simpler the plan the better. However, simplicity is not an end in itself. The question is not whether a plan or program is complicated but whether it is well shaped and designed to produce results. If complicated plans are broken down into subgoals and the strategies or activities needed to accomplish them, they are as capable of being achieved, if the time frame is realistic, as simpler ones. In schematic form, shaping looks like this:

***The case of Harriet: The economics of planning*** Harriet, an undergraduate student at a small state college, wants to become a counselor. Although the college offers no formal program in counseling psychology, with the help of an advisor she identifies several undergraduate courses that would provide some of the foundation for a degree in counseling. One is called Social Problem-Solving Skills; a second, Effective Interpersonal Communication Skills; a third, Developmental Psychology: The Developmental Tasks of Late Adolescence and Early Adulthood. Harriet takes the courses as they come up. Unfortunately, Social Problem-Solving Skills is the first course. The good news is that it includes a great deal of practice in the skills. The bad news is that it assumes competence in interpersonal communication skills. Too late she realizes that she is taking the courses out of optimal sequence. She would be getting much more from the courses had she taken the communication skills course first.

Harriet also volunteers for the dormitory peer-helper program run by the Center for Student Services. The Center’s counselors are very careful in choosing people for the program, but they do not offer much training. It is a learn-as-you-go

approach. Harriet realizes that the developmental psychology course would have helped her enormously in this program. It would have helped her understand both herself and her peers better. She finally realizes that she needs a better plan. In the next semester, she drops out of the peer counselor program. She sits down with one of the Center's psychologists, reviews the schools offerings with him, determines which courses will help her most, and determines the proper sequencing of these courses. He also suggests a couple of courses she could take in a local community college. Harriet's opportunity-development program would have been much more efficient had it been better shaped in the first place.

***The case of Frank revisited*** Let us see what planning might have done for Frank, the vice president who needed leadership skills. In this fantasy, Frank, like Scrooge, gets a second chance.

What does Frank need to do? To become a leader, Frank decides to reset his managerial style with his subordinates by involving them more in decision making. He wants to listen more, set work objectives through dialogue, ask subordinates for suggestions, and delegate more. He knows he should coach his direct reports in keeping with their individual needs, give them feedback on the quality of their work, recognize their contributions, and reward them for achieving results beyond their objectives.

In what sequence should Frank do these things? Frank decides that the first thing he will do is call in each subordinate and ask, "What do you need from me to get your job done? How can I add value to your work? And what management style on my part would help you most?" Their dialogue around these issues will help him tailor his supervisory interventions to the needs of each team member. The second step is also clear. The planning cycle for the business year is about to begin, and each team member needs to know what his or her objectives are. It is a perfect time to begin setting objectives through dialogue rather than simply assigning them. Frank therefore sends a memo to each of his direct reports, asking them to review the company's strategy and business plan and the strategy and plan for each of their functions, and to write down what they think their key managerial objectives for the coming year should be. He asks them to include "stretch" goals.

What is Frank's time frame? Frank calls in each of his subordinates immediately to discuss what they need from him. He completes his objective-setting sessions with them within three weeks. He puts off further action on delegation until he gets a better reading on their performance. This is a rough idea of what a plan for Frank might have looked like and how it might have improved his chaotic and abortive effort to change his managerial style—on the condition, of course, that he was convinced that a different approach to management and supervision made personal and business sense. Box 11.3 is a list of questions you can use to help clients think systematically about crafting a plan to get what they need and want.

### **Claudia's Road to Leadership**

Cliff works with Claudia to make the saying, "Good managers keep the place humming; leaders make it better," a reality in her life and in Astinal generally. She has come to realize the following principles (Egan, 2017) and has begun to

**BOX 11.3****Questions on Planning**

Here are some questions you can help clients ask themselves in order to come up with a viable plan for constructive change.

- Which sequence of actions will get me to my goal?
- Which actions are most critical?
- How important is the order in which these actions take place?
- What is the best time frame for each action?
- Which step of the program needs sub-steps?
- How can I build informality and flexibility into my plan?
- How do I help clients gather the resources, including social support, needed to implement the plan?

apply them to her own life: headship and leadership are not the same thing; while management is about enterprise enhancing results, leadership is about results beyond the ordinary or meeting a recognized standard of excellence; leaders have collaborators rather than followers; leadership should be predicated, not primarily of people but of the enterprise itself, that is, leadership should pervade the enterprise in every aspect and at all levels; organizations should have a leadership culture; there should be leaders everywhere. Slaughter (2017) calls this “system leadership.”

Leadership is about action. Cliff helps Claudia become a leadership agent by putting into practice the six dimensions of a leadership process (Egan, 2017):

1. *A Flow of Creative Ideas.* She facilitates the flow of enterprise-enhancing ideas throughout the hospital. She offers some ideas of her own, but encourages others, especially those who report to her, to let innovative ideas flow. For instance, she thinks that a “medical-care basics” checklist (Gawande, 2011) will add a great deal of value not just in the OR but throughout the hospital.
2. *Choosing the Best.* From the flow, she and others on the leadership track choose the best ideas for implementation. “Best” here means ideas that will add most value to the enterprise, some kind of combination of effectiveness and efficiency. Terrence believes that teamwork in the OR will add a great deal of value.
3. *From Creativity to Innovation.* Creative ideas, on their own, do nothing. They must be embedded in a product or project or program that adds actual value. Teamwork is embedded in a teamwork development program the results of which are carefully measured. For Claudia the good idea, “leadership,” is embedded in the six-step process being outlined here.
4. *“Selling” the Innovation Internally.* Success requires collaboration. Leaders must sell their products or projects or programs internally to those who must work together to deliver the results. Terrence talks to the heads of all the departments in order to get them on board the Checklist innovation. Claudia “sells” the idea of Astinal as a leadership enterprise, that is, an enterprise in which these six steps are embedded in its culture.

5. *Creating a Climate of Support.* Claudia helps create a climate of learning, innovation, and problem solving and helps others to do the same. All together they help “keep the creative juices” flowing. The ferment created around the projects and programs brings out the creativity of those involved in developing and implementing them. The way “turned on” collaborators implement projects itself stimulates new learning. Creative ways of addressing obstacles are found.
6. *Persistence in Getting Results.* Since leadership is about results, leaders play a critical role in seeing to it that the group's effort is successful. Claudia is persistent. She sees agendas through to completion and helps others do the same. Leaders do not let go. They get things done. In one sense, they do not know the meaning of failure. If they can't move one way, they will move another. Setbacks, possibly, but failure, no. It's not word in their vocabulary.

## Humanize the Mechanics of Problem Management and Opportunity Development LO 11.6

Some years ago I lent a friend of mine an excellent, though somewhat detailed, book on self-development. About two weeks later he came back, threw the book on my desk, and said, “Who would go through all of that!” I retorted, “Perhaps someone really interested in self-development.” That was the righteous, not the realistic, response. Planning in the real world seldom looks like planning in textbooks. Textbooks do provide useful frameworks, principles, and processes, but they are seldom implemented exactly as they are outlined. Most people are too impatient to do the kind of planning just outlined. One of the reasons for the dismal track record of discretionary change mentioned in Chapter 2 is that even when clients do set realistic goals, they lack the discipline to develop reasonable plans. The detailed work of planning is too burdensome.

Therefore Stages II and III of the helping process together with their six tasks need a human face. If helpers skip the goal-setting and planning steps clients need, they shortchange them. On the other hand, if they are pedantic, mechanistic, or awkward in their attempts to help clients engage in these steps—failing to give these processes a human face—they run the risk of alienating the people they are trying to serve. Clients might well say, “I’m getting a lot of boring garbage from him.” Here, then, are some principles to guide the constructive-change process.

### Build a Planning Mentality into the Helping Process Right from the Start

A constructive-change mind-set should permeate the helping process right from the beginning. Helpers need to see clients as self-healing agents capable of changing their lives, not just as individuals mired in problem situations. Even while listening to a client's story, the helper needs to begin thinking of how the situation can be remedied and through probes find out what approaches to change clients are thinking about—no matter how tentative these ideas might



be. As mentioned earlier, helping clients act in their real world right from the beginning of the helping process helps them develop some kind of initial planning mentality. If helping is to be solution-focused, thinking about strategies and plans must be introduced early. When a client tells of some problem, the helper can ask early on, “What kinds of things have you done so far to try to cope with the problem?”

Cora, a battered spouse, did not want to leave her husband because of the kids. Right from the beginning, the helper saw Cora’s problem situation from the point of view of the whole helping process. While she listened to Cora’s story, without distorting it, she saw possible goals and strategies. Within the helping sessions, the counselor helped Cora learn a great deal about how battered women typically respond to their plight and how dysfunctional some of those responses are. She also learned how to stop blaming herself for the violence and to overcome her fears of developing more active coping strategies. At home she confronted her husband and stopped submitting to the violence in a vain attempt to avoid further abuse. She also joined a local self-help group for battered women. There she found social support and learned how to invoke both police protection and recourse through the courts. Further sessions with the counselor helped her gradually change her identity from battered woman to survivor and, eventually, to doer. She moved from simply facing problems to developing opportunities.

Constructive-change scenarios like this must be in the helper’s mind from the start, not as preset programs to be imposed on clients but as part of a constructive-change mentality.

### **Adapt the Helping Process to the Style of the Client**

Setting goals, devising strategies, and making and implementing plans can be done formally or informally. Kirschenbaum (1985) challenged the notion that planning should always provide an exact blueprint for specific actions, their sequencing, and the time frame. He suggested that helpers consider these three questions:

- How specific do the activities have to be?
- How rigid does the order have to be?
- How soon does each activity have to be carried out?

Kirschenbaum (p. 492) suggested that, at least in some cases, being less specific and rigid about actions, sequencing, and deadlines can “encourage people to pursue their goals by continually and flexibly choosing their activities.” That is, flexibility in planning can help clients become more self-reliant and proactive. There is a continuum. Some clients actually like the detailed work of devising plans; it fits their style. Consider the following two cases.

Rebecca sought counseling as she entered the “empty nest” period of her life. Although there were no specific problems, she saw too much emptiness as she looked into the future. The counselor helped her see this period of life as a normal experience rather than a psychological problem. It was a developmental opportunity and challenge (see Raup & Myers, 1989). It was an opportunity to reset her life. After spending a bit of time discussing some of the maladaptive responses to this transitional phase of life, they embarked on a review of possible scenarios. Gitta loved



brainstorming, getting into the details of the scenarios, weighing choices, setting strategies, and making formal plans. She had been running her household this way for years. So the process was familiar even though the content was new.

Connor also benefited by-the-letter planning.

Connor, rebuilding his life after a serious automobile accident, very deliberately planned both a rehabilitation program and a career change. Keeping to a schedule of carefully planned actions not only helped him keep his spirits up but also helped him accomplish a succession of goals. These small triumphs buoyed his spirits and moved him, however slowly, along the rehabilitation path.

Both Rebecca and Connor readily embraced the positive approach embedded in constructive change programs. They thrived on both the work and the discipline to develop plans and execute them. However, many, if not most, people are not like Gitta and Connor. The distribution is skewed toward the “I hate all this detail and won’t do it” end of the continuum. Rigid planning strategies can lead to frequent failure to achieve short-term goals. Consider the case of Yousef.

Yousef was a single parent with a mentally retarded son. A colleague at work challenged him one day. “You’ve let your son become a ball and chain and that’s not good for you or him!” his friend said. Yousef smarted from the remark, but eventually—and reluctantly—sought counseling. He never discussed any kind of extensive change program with his helper, but with a little stimulation from her he began doing little things differently at home. When he came home from work especially tired and frustrated, he had a friend in the apartment building stop by. This helped him to refrain from taking his frustrations out on his son. Then, instead of staying cooped up over the weekend, he found simple things to do that eased tensions, such as going to the zoo and to the art museum with a woman friend and his son. He discovered that his son enjoyed these pastimes immensely despite his limitations. In short, he discovered little ways of blending caring for his son with a better social life. His counselor had a constructive-change mentality right from the beginning but did not try to engage Yousef in overly formal planning activities.

Of course, a slipshod approach to planning—“I will have to pull myself together one of these days”—is also self-defeating. We need only look at our own experience to see that such an approach can be fatal.

Overall, counselors should help clients embrace the kind of rigor in planning that make sense for them in their situations. There are no formulas; there are only client needs, planning skills, and common sense. Some things need to be done now, some later. Some clients need more slack than others. Sometimes it helps to spell out the actions that need to be done in quite specific terms; at other times it is necessary only to help clients outline them in broad terms and leave the rest to their own sound judgment. If therapy is to be brief, help clients start doing things that lead to their goals. Then, in a later session, help them review what they have been doing, drop what is not working, continue what is working, add more effective strategies, and put more organization in their programs. If you have a limited number of sessions with a client, you can’t engage in extensive goal setting and planning. “What can I do that will add most value?” is the ongoing challenge in brief therapy.

## **Devise a Plan for the Client and Then Help the Client Tailor It to His or Her Needs**

The more experienced helpers become, the more they learn about the elements of program development and the more they come to know what kinds of programs work for different clients. They build up a stockpile of useful programs and know how to stitch pieces of different programs together to create new programs. And so they can use their knowledge and experience to fashion a plan for any clients who lack the skills or the temperament to pull together a plan for themselves. Of course, their objective is not to foster dependence but to help clients grow in self-determination. For instance, they can first offer a plan as a sketch or in outline form rather than as a detailed program. Helpers then work with clients to fill out the sketch and adapt it to their needs and style. Consider the following case.

Katrina, a woman who dropped out of high school but managed to get a high school equivalency diploma, was overweight and reclusive. Over the years she had restricted her activities because of her weight. Sporadic attempts at dieting had left her even heavier. Because she was chronically depressed and had little imagination, she was not able to come up with any kind of coherent plan. Once her counselor understood the dimensions of Katrina's problem situation, she pulled together an outline of a change program that included such things as blame reduction, the redefinition of beauty, decreasing self-imposed social restrictions, cognitive restructuring activities aimed at lessening depression. She also provided information about obesity and suggestions for dealing with it drawn from health-care sources. She presented these in a simple format, adding detail only for the sake of clarity. She added further detail as Katrina got involved in the planning process and in making choices.

Although this counselor pulled together elements of a range of already existing programs, counselors are, of course, free to make up their own programs based on their expertise and experience. The point is to give clients something to work with, something to get involved in. The elaboration of the plan emerges through dialogue with the client and in the kind of detail the client can handle.

The ultimate test of the effectiveness of plans lies in the problem-managing and opportunity-developing action clients engage in to get what they need and want. There is no such thing as a good plan in and of itself. Life-enhancing outcomes, not planning or hard work, are the final arbiter.

## **Help Clients Develop Contingency Plans**

If the future is uncertain, it pays to have a broad range of options open. There is no use investing a great deal of time and energy in a goal or in a program to accomplish a goal that will have to be changed because the client's world changes. Therefore help clients choose one or more backup goals to take care of such eventualities. In this way, clients have direction, but they also have contingency. If the world changes, then the client can choose the goal that best fits the circumstances at the time. So choosing a goal or a program to achieve a goal is not necessarily a once-and-forever decision. The client says to herself, "I'll stick with this goal until I see that it is no longer viable. Or until a better goal emerges." Having viable options helps you kill, or at least put on the back burner, an option that is no longer working. Backup plans provide freedom and flexibility. They also keep clients from falling into the status quo decision-making trap outlined earlier. Consider Linda's case.

Linda is a young woman working for a computer firm in Mexico. She was born and raised in Iraq. She has made a tortuous journey through South and Central America as an illegal immigrant. Her journey included prostitution and a range of harrowing, even life-threatening, experiences. The upside of all this is that she has learned to live by her wits. After returning from an illegal trip to the United States, she has one goal—to live there permanently. She takes counsel with a friend of hers, a lawyer in Mexico, telling him of her plan to live as an illegal in the United States. Both intelligent and socially savvy, she feels that she can pull it off.

Her lawyer friend, knowing that her ultimate goal is to live permanently in the United States, helps her review a range of instrumental goals—goals in themselves but steps toward helping her achieve her ultimate goal. They discuss possibilities. Options other than living by her wits as an illegal immigrant include obtaining political refugee status, becoming a green card holder, marrying a U.S. citizen, marrying a foreigner who is most likely to get a green card, and being included in the quota of immigrants allowed permanent resident status because they have essential skills such as those needed in booming technology industries. A plan would be needed to pursue each of these. Linda's future is certainly filled with risk and uncertainty. She has to choose an instrumental goal that she thinks offers the best possibility for achieving her ultimate goal, but after her discussion she has a range of fallback options.

If at times goals need to be changed—"If I do not get into medical school, then the nurse-practitioner route is still attractive"—it is also true that strategies for achieving goals might have to change. Contingency plans answer the question, "What will I do if the plan of action I choose is not working?" They help make clients more effective tacticians. We make contingency plans because we live in an imperfect world.

Jackson, the man dying of cancer, decided to become a resident in the hospice he had visited. The hospice had an entire program in place for helping patients like Jackson die with dignity. Once there, however, he had second thoughts. He felt incarcerated. Fortunately, he had worked out alternative scenarios with his helper. One was living at the home of an aunt he loved and who loved him dearly, with some outreach services from the hospice. He moved out of the hospice into his aunt's home and then spent his final days at the hospice.

Contingency plans are needed especially when clients choose a high-risk program to achieve a critical goal. Having backup plans also helps clients develop more responsibility. If they see that a plan is not working, then they have to decide whether to try the contingency plan. Backup plans need not be complicated. A counselor might merely ask, "If that doesn't work, then what will you do?" As in the case of Jackson, clients can be helped to specify a contingency plan further once it is clear that the first choice is not working out.

## Come to Terms with the Explosion of Evidence-Based Treatments **LO 11.7**

There is a history of ready-made programs for clients. There have always been any number of tried-and-true constructive-change programs. The 12-step approach of Alcoholics Anonymous is one of the most well-known. It has been adapted to other forms of substance abuse and addiction. Some people swear by this program, but, as you might expect in the helping industry, others challenge both

its science and its efficacy (Lewis, 2015). Systematic desensitization, a behavioral program, has long been used to treat clients suffering from such disorders as phobias and the symptoms of PTSD. Such programs might include sessions in muscle relaxation, the development of a fear hierarchy, and weekly sessions in the systematic desensitization of these fears. They can help alleviate such debilitating conditions as intrusive thoughts, panic attacks, and episodic depression.

Not all ready-made programs focus on remediation. For instance, while there are a number of treatment programs for clients with histories of pedophilia, prevention programs are much scarcer. Consider this case.

After a couple of rather aimless sessions, the helper said to Fabian, “We’ve talked about a lot of things, but I’m still not sure why you came in the first place.” This challenged Ahmed to reveal the central issue, though he needed a great deal of help to do so. It turned out that Ahmed was sexually attracted to prepubescent children of both sexes. Although he had never engaged in pedophilic behavior, the temptation to do so was growing.

The counselor adapted a New Zealand program called *Kia Marama* (Hudson, Marshall, Ward, Johnston et al., 1995), a comprehensive cognitive-behavioral program for incarcerated child molesters, to Fabian’s situation. The original program includes intensive work in challenging distorted attitudes, reviewing a wide range of sexual issues, seeing the world from the victim’s point of view, developing problem-solving and interpersonal-relationship skills, stress management, and relapse-prevention training. Fabian and his counselor spent some time assessing which parts of the program might be of most help before embarking on an intensive tailored program.

The economics of prevention far outweigh the economics of rehabilitation. Not only did Fabian stay out of trouble, but much of what he learned from the program—for instance, stress management—also applied to other areas of his life.

### **Familiarize Yourself with General Well-Being Programs: Nutrition, Exercise, and Stress Reduction**

Programs that contribute to general well-being can be used as adjuncts to all approaches to helping. *Changing Unhealthy Habits* (a supplement to the *Mayo Clinic Health Letter*, February, 2007) is typical of the practical science-based literature that forms the basis of general well-being programs. This literature reviews the research and packages the results in practical ways to appeal to both practitioners and clients.

Researchers have indicated that if people generally were to eat properly, exercise regularly, stop putting toxins in their bodies, and reduce and manage stress in their lives, our national health-care bill would be reduced by some 30%. One wonders why we have heard nothing about this from politicians on both sides of the aisle amid the din and cry around health-care legislation. Indeed there are many ready-made programs in the areas of nutrition, exercise, substance abuse, and stress management.

**Nutrition** In many ways we are what we eat. But it is not just a question of obesity. Many of us could achieve significant health benefits by losing just a few pounds (Martin, 2002). Researchers tell us that the incidence of certain kinds of

cancer could be cut in half if we were to avoid toxins in the environment and eat well. As helpers, we cannot afford to remain ignorant of the role of a good diet in mental health and of programs that promote healthy eating. The best place to start, of course, is with ourselves. The Mayo Clinic supplement suggests four simple, but not necessarily easy, steps to changing unhealthy habits such as poor eating and overeating. The first two are readiness-for-change factors discussed earlier. First, make sure that you have the physical and mental energy for a change program. Second, do a physical, psychological, and motivational self-assessment to make sure you are ready for change. Third, create a plan using the principles in this chapter. Fourth, read Chapter 8 again and then get started. The Mayo supplement also has a good section on the difference between pure willpower and self-control skills.

**Exercise** When it comes to exercise, we know what we are supposed to do. We just do not do it ([https://hms.harvard.edu/sites/default/files/assets/Sites/Longwood\\_Seminars/Exercise3.14.pdf](https://hms.harvard.edu/sites/default/files/assets/Sites/Longwood_Seminars/Exercise3.14.pdf), Arany & Davis, 2014; DeAngelis, 2002; Johnson, L., 2010; Landro, 2010; Nieman, 2010; Ratey & Hagerman, 2008; Servan-Schreiber, 2004). Self-efficacy often improves with exercise (McAuley, Mihalko, & Bane, 1997), that is, exercise has a way of becoming more than exercise. It has a spread effect in our lives. Exercise improves not just the body but also the mind and the spirit. In one study, Blumenthal and his associates (2007) wanted to see whether patients suffering from major depression receiving aerobic exercise training would achieve reductions in depression comparable to those coming from anti-depressant medication and placebos. All in all, 41% of those participating in the study achieved remission. He found that patients who engaged in exercise received benefits equal to those taking medication. Both these groups beat out the placebo group. It should be noted, however, that the placebo group did fairly well. Medina (2008) points out that neuroscience shows that exercise neutralizes harmful stress chemicals and contributes to improvement in problem-solving and planning. The self-discipline developed through exercise programs can be a stimulus to increased self-regulation in other areas of life. There is evidence showing that exercise programs can help in the treatment of schizophrenia and alcohol dependence (Read & Brown, 2003; Tkachuk & Martin, 1999). Such programs also help more directly to reduce depression, manage chronic pain, and control anxiety. Kate Hays (1999) has done a comprehensive review of the positive impact of exercise in *Working It Out: Using Exercise in Psychotherapy*. I remember once when I was getting ready to the gym for some exercise, a voice within me said, “Not today.” When I hesitated, I asked myself: “Have you ever regretted exercising even when you didn’t feel like doing it?” The answer, “Never.” I headed out the door.

**Stress reduction** There is good stress and bad stress. Most of us know the difference. When Michelle says, “What I like most about my job is that it is *challenging*,” she is talking about good stress. When a mother wrings her hands and says, “I just know what I’m going to do about my teenage daughter,” she is talking about bad stress. The clients we see have plenty of bad stress. Medina

(2008; *Harvard Business Review*, May, 2008) taps into neuroscience to describe the effects of bad stress:

Stress damages virtually every kind of cognition that exists. It damages memory and executive function. It can hurt your motor skills. When you are stressed out over a long period of time it disrupts your immune response. You get sick more often. It disrupts your ability to sleep. You get depressed. (Sourced on November 23, 2008 at <http://www.brainrules.net/stress>)

There are all sorts of stress-reduction programs, old and new, that can become adjuncts to therapy. One of the oldest (first published in 1975 and revised in 2000) was pioneered by Herbert Benson (see Martin, 2008) and is called the “relaxation response.” His is a simple program that leads to a “physical state of deep rest that changes a person’s physical and emotional responses to stress” (Martin, p. 33). According to Benson (see Kersting, 2005), stress hormones, produced when the body’s “fight or flight” response is triggered, play a role in a host of ailments including hypertension, anxiety, depression, infertility, hot flashes in menopause, and insomnia. Benson has demonstrated that relaxation techniques such as meditation and prayer can help undo the damage done by stress hormones, and should be considered an essential element of health care. Another long-term favorite (now in its 6th edition) on stress reduction techniques is the David, Eshelman, McKay, and Fanning (2008) workbook.

So if nutrition, exercise, and stress management work so well, why do not more people use them? Why do not they play a bigger part in therapy? One answer is that all three can be seen as prevention programs. The problem with prevention is this: if it works something (bad) does not happen. It’s hard to appreciate a vacuum. To be fair, all three programs do more than eliminate bad things. They make life fuller, richer. But that’s not the way people see them. They see the restrictions and the work and shy away. Dieting is a bad word; nutrition is an upbeat word. If these practices are to become adjuncts to our therapy practice, we have to find ways to make them upbeat and interesting. But first we must see them as important.

### **In Choosing Evidence-Based Treatments, Start with Clients’ Needs**

In our experience clients arrive with a number of different, often interrelated, problems together with a variety of symptoms. They often come with complicated problems in living. The starting point is the client in all his or her complexity, not the intervention strategy. Still, carefully chosen evidence-based practices can be constructively incorporated into the helping process. What kinds of treatments are available? There are treatments and manuals on how to use these treatments.

Many clients have problem situations rather than specific problems such as phobias or PTSD symptoms. Or they have both. Many of the cases reviewed in this book focus on clients with complex problems in living that are not amenable to manualized treatments. Manuals are used when the “diagnosis” is clear and the desired outcomes are clear. However, because anxiety and stress are part of most problem situations, manualized treatments for them can play an important role (Lebow, 2006).



Lebow outlines what he calls the “incontestable track record” (2006, p. 77) **evidence-based treatments** have in helping clients deal with the anxiety related to panic disorders, obsessive-compulsive behavior, simple phobias, and generalized anxiety disorder. He claims that the evidence for the effectiveness of such treatments is so strong that, “as responsible therapists, we need to know how to practice these techniques or be prepared to refer these clients to therapists who do” (p. 79). In the end, theory, research, and ideology need to serve or give way to the needs of clients.

**Treatments** Treatments have been developed for a wide range of human problems (Goodheart, 2006; Nathan & Gorman, 2002), including anxiety (Sheldon, 2008), chronic pain (Field & Swarm, 2008) phobias, depression (Sturmey, 2009), bipolar disorder (Reiser, Thompson, Johnson, & Suppes, 2017), posttraumatic stress disorder, substance abuse, panic, and borderline personality disorder. There are treatments tailored to specific populations, for instance, older adults (Kropf & Cummings, 2017). There are treatments for different models of therapy (Dobson & Dobson, 2017). There are treatments for therapeutic methods such as mindfulness (Witkiewitz et al., 2017). New manuals for different psychological disorders are being created continually. Indeed, merely reading through Chambless’s (2005) compendium of **empirically supported treatments** and Lambert et al.’s (1995) compendium of psychotherapy treatment manuals is daunting. One publisher, Hogrefe & Huber, in cooperation with the Society of Clinical Psychology (APA Division 12) has begun to publish manuals in its *Advances in Psychotherapy—Evidence-Based Practice* series. Each book in the series is a compact “how-to” reference on a particular disorder. Topics include bipolar disorder, heart disease, obsessive-compulsive disorder, childhood maltreatment, schizophrenia, and problem/pathological gambling. So, as you can see, it is impossible to treat evidence-based treatments substantively in this book. It is a whole world that you will have to discover for yourself.

**Manuals** Many treatments have been “manualized.” Manuals outline step-by-step processes and programs for helping clients achieve a specific goal, such as reducing the debilitating symptoms of PTSD. Manuals describe how to deliver treatment for a particular kind of disorder such as agoraphobia (Barlow, 2004; Rothbaum, 2006). Some are written for practitioners (Barlow, 2004; Zuercher-White, 1998), some as self-help guides for clients (Pollard & Zuercher, 2003), and some for both helpers and clients (Andrews et al., 2002).

There are both problems and possibilities associated with evidence-based practice treatments. Randomized trials constitute an important research methodology in the development of evidence-based treatments. But randomized trials, however important in medicine, constitute both a plus and a minus in helping practice.

A randomized trial can prove that a remedy works, without necessarily showing why. It may not do much to illuminate the mechanisms between the lever the experimenters pull and the results they measure. This makes it harder to predict how other people would respond to the remedy or how the same people would respond to an alternative. And even if the trial works on average that does not mean it will work for any particular individual. (*The Economist*, 2009, January 3, p. 59)



Your major criterion should be useful for your clients, that is, useful for *this* client. The January 2006 issue of *The American Psychologist* (Volume 61, Number 1) is devoted in large part to the concept of “arbitrary metrics.” It is well worth reading because it challenges the way we “prove” things in psychology. Kazdin (2006, p. 42) applies the concept of arbitrary metrics to evidence-based treatments: “Research designed to establish the empirical underpinnings of psychotherapy relies heavily on arbitrary metrics, and researchers often do not know if clients receiving an evidence-based treatment have improved in everyday life or changed in a way that makes a difference, apart from the changes the arbitrary metrics may have shown.” The points he makes do not constitute an attack on evidence-based treatments. Rather, they are a plea for linking measurements to life-enhancing outcomes.

### **Learn the Value of Both Evidence-Based Practice and Practice-Based Evidence from the Evidence-Based Treatment Debate**

The explosion in ready-made programs has led to quite a debate among researchers and practitioners (Goodheart, Kazdin, & Sternberg, 2006; Hunsley, 2007; Kazdin, 2008; Levant & Hasan, 2008; Norcross, Beutler, & Levant, 2005; Weisz, Weersing, & Henggeler, 2005; Westen, Novotny, & Thompson-Brenner, 2004, 2005). The debate is highly polarized—pro and con. For instance, on the “pro” side is a study of 47 therapists’ views of treatment manuals (Najavits, Weiss, Shaw, & Dierberger, 2000). Findings indicated that helpers had a very positive view of manuals, used them extensively, and had few concerns with them. However, four years later, the findings from a study from the same research setting (Najavits et al., 2004) were more nuanced: “Therapists were highly positive about the treatments. However, their likelihood of using them in the future without modification was low, and they viewed them as too short. Supervision was seen as more important than manuals and taping of sessions more important than adherence scales. It took therapists an average of 8 months to feel comfortable with the treatments” (p. 26).

On the down side, Garfield (1996) responded to guidelines on the use of empirically validated treatments issued by the Division of Clinical Psychology of the American Psychological Association (Division 12 Task Force, 1995). He expressed a range of concerns that have since been echoed and amplified by other researchers and practitioners. Some common concerns are that the language of the Task Force report was too strong, some of its recommendations were premature, manuals often idealize and thus distort psychotherapy, the research base underpinning some manuals is questionable, clients are messy and do not come to therapy with neatly categorized problems, studies do not factor in the competence (or the lack thereof) of the therapists involved, manuals ignore the role of the therapist as model of adult living, the place of art and clinical judgment is demeaned or ignored (see Soldz & McCullough, 2000; Waddington, 1997), and manual treatments are often highly specialized, cumbersome, time consuming, expensive, and not user friendly.

One of the major annoyances for many is that the evidence-based practice movement seems to require buying into the medical model of psychological treatment (Barlow, 2004). In an historical examination of evidence-based practice,

Wampold and Bhati (2004) found that evidence-based treatments overemphasize treatments and treatment differences and ignore aspects of therapy demonstrated to be related to positive outcomes, such as variations among psychologists, the helping relationship, the subjective experience of the client, and other common factors. Furthermore, manuals focus on problems—not on the development of opportunities, which should be one of the principal forms of helping.

**Confusing complexity** Complexity makes choosing the right evidence-based treatment at the right time difficult (Buggati & Boswell, 2016). One strong voice in the practice of psychology urges us to honor diversity and focus on the individual client. Another strong voice urges practitioners to base everything they do on evidence. This creates a dilemma. Take alcoholism. Recently the National Institute on Alcohol Abuse and Alcoholism that there are at least five subtypes of alcoholics (Moss, Chen, & Yi, 2007). These include young adult alcoholics (31.5%), young antisocial alcoholics (21%), functional alcoholics (19.5%), intermediate familial alcoholics (19%), and chronic severe alcoholics (9%). Each group has its own generic profile or set of characteristics. Alcoholics are not a single, monolithic group. As a consequence it seems that we cannot ask simplistically, “How do we treat alcoholics.” Some can rightly ask, “Which kind of alcoholic?” Furthermore, individuals in each of these categories have his or her own set of characteristics. Do we need an evidence-based treatment for each of these categories that can be further tailored to the needs of each individual? We do know that alcoholics want and/or need help.

Krause, Lutz, and Saunders (2007) add to the dilemma. They say that therapists, not treatment forms, actually treat clients. They conclude “what should primarily be given preference in practice is not treatments empirically certified on the basis of their results in randomized clinical trials but psychotherapists empirically certified to practice on the basis of their results in actual practice” (p. 347). What is *this* therapist’s track record in dealing with alcoholics? They go on to say that “what is needed is the routine study of the results of ordinary practice” (p. 348), echoing the approach taken by Miller, Hubble, and Duncan (2007). But the profession itself has not even embarked on this journey nor does anyone know how feasible it is.

Of course, the larger the treatment protocol the more difficult it is to have a research base for each element in the protocol and the unified protocol itself. For instance, Calley (2007), in discussing a research-based treatment program for juvenile male sex offenders, lists a dozen issues to be included in the seven-module treatment protocol ranging from “resolution of victimization in the history of the offender” to “development of relapse prevention strategies” (p. 133). She adds that “sound” treatment framework is needed to unify all these elements and suggests a cognitive-behavioral approach. Indeed, the framework being discussed and illustrated in this book seems to fit the bill. I would suggest that a rigorous study of the effectiveness (outcomes) of the treatment protocol is called for, whether such program evaluation can be called “science” or not.

**The need for common sense** More common sense and balance are needed in this debate (Deegear & Lawson, 2003). Many psychologists see manuals as just

another tool and fold them into their practice whenever they are deemed useful (Weisz, Sandler, Durlak, & Anton, 2005). Others see the need to tailor such programs to the individual (Nicholson, Anderson, Fox, & Brenner, 2002; Schmidt & Taylor, 2002). Still others want more research into manualized treatments to start and end with real clients and based on case studies (Edwards, Dattilio, & Bromley, 2004; Messer, 2004). If you intend to become a professional helper, you will have to come to terms with the evidence-based practice controversy and treatment manuals. Current literature on these topics is rich, thought provoking, political, and confusing. Treatment manuals are not going to go away (Foxhall, 2000), nor is the controversy they have precipitated.

***The self-help literature*** Finally, not all useful ready-made programs are found in sophisticated evidence-based manuals. Many are found in the best of the self-help literature that focuses on a wide variety of psychological problems. The best are realistic, practical, and translations of some of the best thinking in the field or a “manualization” of common sense. John Norcross and his colleagues (2003) have published a useful “authoritative guide” to self-help resources in mental health. Redding, Herbert, Forman, and Gaudiano (2008) reviewed and rated 50 “top-selling” self-help books. They found that the “most highly rated books tended to be those having a cognitive behavioral perspective, those written by mental health professionals, those written by authors holding a doctoral degree, and those focusing on specific problems” (p. 537). However, their “cautions” section at the end of their article adds up to this: their choices might well be biased and their conclusions are certainly not “scientific.” Of course, this does not mean that their reviews are not useful.

### **Sometimes Evidenced-Based Treatments Do Not Work; Sometimes Non-Evidence-Based Treatments Do Work**

There is nothing magic about any kind of psychological treatment. People are too complicated for that. Here is an example of an evidenced-based treatment that did not work. The following case is presented to give focus to this debate, which abounds in ambiguities. The case is more about the ambiguities of treatment than their validity.

Theo was a marine who had been deployed to Iraq. Before he went he attended an educational program called “Battlemind” (see [www.battlemind.org](http://www.battlemind.org)) designed to help military personnel do two things: first, understand and face the realities of battle, develop the strength to face fear and adversity with courage, and become more resilient after inevitable setbacks; second, help combat troops become aware of and learn how to deal with common challenges they face when they return home. For instance, one module deals with emotional control (critical for mission success) versus emotional detachment (a cause of relationship failures upon returning home). It is, in a sense, a “forewarned is forearmed” prevention program targeting both PTSD and post-deployment problems.

The program did not seem to work for Theo either on the battlefield or when he returned home. After a few combat missions he began to show many of the symptoms of posttraumatic stress disorder (PTSD) such as hyperarousal, anxiety, and social withdrawal. PTSD is not a disease but rather a cognitive-behavioral-emotional-social syndrome. His behavior became erratic and he had alarming mood swings. It

soon became evident that he was a danger to both himself and others. He was withdrawn from combat and placed in a short recovery program in a military hospital in Germany. He was then sent home.

At home everything fell part because his wife had learned that before deployment he had had an affair with a woman who worked at the base. At times it was hard to tell whether he or his wife was in the worse shape. Both attended separate programs, which were to be followed by marriage counseling. Strange to say (or not), she ultimately responded well to a systematic PTSD program after showing many of the symptoms of that syndrome. Finding out that her husband had had an affair was the most traumatic thing that had ever happened to her. He ultimately did best with a minister who used common pastoral counseling techniques. He had been raised in a fundamental Christian denomination and still responded to its language of sin, redemption, and salvation. Theo felt that he had betrayed his wife, his country, and his God and atonement was part of the route back to sanity.

I am sure that Battlemind and similar evidence-based treatments have helped many military personnel deal with the challenges of combat more effectively and/or deal with social-psychological challenges of returning home. The fact that it did not seem to help Theo at all is beside the point. I also doubt that a systematic PTSD therapy program is not the first treatment one would think of when it comes to helping someone deal with the shock of infidelity. And pastoral counseling is not a frontline PTSD treatment.

Here is a non-evidence-based program that did work. A community-based mental health center got involved with a program for people on welfare. When new legislation was passed forcing welfare recipients to get work, programs that helped people on welfare get and keep jobs were needed. The mental health center learned a great deal from one program sponsored by a major hotel chain (see Milbank, 1996). The hotel chain began to hire welfare recipients because it made both economic and social sense. Because of the problems with this particular population, however, the hotel's recruiters, trainers, and supervisors had to become paraprofessional helpers, though they never used that term. The people they recruited—battered women, ex-convicts, addicts, homeless people, including those who had been thrown out of shelters, and so forth—had all sorts of problems. A lot of the help was social rather than psychological. "They drive welfare trainees to work, arrange their day care, negotiate with their landlords, bicker with their case workers, buy them clothes, visit them at home, coach them in everything from banking skills to self-respect and promise those who stick with it full-time jobs" (Milbank, 1996, p. A1). The trainers also challenged a common mind-set among the trainees; "I am not responsible for myself." The hotel program was far from perfect, but it did help many of the participants develop much-needed self-discipline and find a new life both at work and outside.

In the end much of the help was psychological. The counselors from the mental health center who acted as consultants to the program learned that some of the new employees benefited greatly from upfront involvement of trainers and supervisors in their lives. They also saw that the recruiters, trainers, and supervisors also benefited. So they started a volunteer program at the mental health center, looking for people willing to do the kinds of things that the hotel trainers and supervisors did. They knew that both the clients and the volunteers would benefit.

Obviously, the helping professions are on a journey toward best practice, a journey that might well be endless. In the meantime, it is not a question of accepting or rejecting evidence-based treatments but of using a critical client-focused clinical eye to integrate selective treatments into your practice according to the needs of your clients. In the end, therapeutic outcomes trump therapeutic methodologies. Is second-order change that focuses on outcomes (Fraser & Solovey, 2007) the answer to the debate? Perhaps, but count on the debate going on indefinitely because the deeper foundations of the debate, the very nature of social science, have not been sufficiently explored. And the debate is not just about science. A great deal of it is about professional politics.

## One Final Reminder

Client-centered flexibility is the norm. Forget the linear logic of the helping process described here. Turn that logic into a set of “moves” you can make to help clients manage their lives better. Learn how to live with the lack of logic many clients bring with them. Become a helping entrepreneur!

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